The People's Flag *Malcolm Muggeridge*

THE NEW REPUBLIC

November 9, 1963, 35 cents

HEALTH:

Are We the People Getting Our Money's Worth?

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T.R.B. from Washington

Goldwater Jitters

★ A well-known European publisher was asked here last week the effect of Goldwater's candidacy abroad. He said it would cause absolute panic among America's allies if the Arizonian were nominated, or even came within reach of the nomination. Goldwater has already produced the gloomiest apprehension on Embassy Row, where home governments are burning the cables with questions whether the USA is going to have another of its strange seizures.

Consider the situation: In Dallas Adlai Stevenson is spat on; in New York Earl Warren is hit with placards; all over the country the infectious virus of broadcasts like H. L. Hunt's primitive nationalism is being injected into the body politic. Then Goldwater comes along with a record of utterances that would scare any European.

Are these fears silly? Well, yes, probably, we should say; but who are we to know? In the past Goldwater has all but preached preventive war; he has toyed with the notion of using nuclear weapons against the Soviets or at least he has given that impression – though nobody really knows whether this was just talk.

Just lately Governor Rockefeller has recalled that Goldwater proposed leaving to American field commanders abroad discretion on using nuclear bombs. Imagine the cold chill this causes the French, Germans or Russians. Europeans look and ask, What is going on in America, anyway? and the uncertain embassies here try to reassure them. But can they? Just the other day Goldwater said he thought the danger was too much *civilian* control of the military. It may be fun for Americans, but it scares Europeans.

"Hold Your Nose . . ."

★ We got to thinking the other day what going through another election with the Luce publications is going to be like. "Hold Your Nose At Bobby's Pork" says a *Life* editorial (Oct. 18), explaining that the Attorney General, among other things, blocks the Pennsylvania-NY Central merger for political reasons. He won't pass it, it seems, unless the big roads take care of the bankrupt New Haven, and the Boston & Maine, too. Holding its nose as it reveals the plot, the editorial whispers that the New Haven and B & M "serve Massachusetts." See? The Kennedys *come from Massachusetts!* The nation, says *Life*, must now "suffer the Kennedys in a political mood, *i.e.*, at their very worst."

Well, of course, the two orphan roads also serve the rest of New England (and New York, too), but what has logic to do with editorial prejudice? And we shall have 12 more months of it.

Indeed, the Luces are in a political mood, *i.e.*, at their very worst. A bitter article in *Time*, Sept. 20, charged that US correspondents, led by the *NY Times*, were carrying on the equivalent of a conspiracy to defame the poor, dear Diem regime in Saigon, where, among other things, they "seldom miss a chance to overemphasize the ruling family's Roman Catholicism." Now we note full page advertisements in NY newspapers from William F. Buckley, Jr's well-heeled *National Review* with excerpts from Clare Booth Luce's defense of poor, misunderstood Madame Nhu. "Is the history of the Liberal press in Chungking and Havana going to repeat itself" in Vietnam? cries Mrs. Luce, and replies, "The evidence is that it is."

Evidently this is part of the *Time* Saigon campaign. The two *Time* correspondents in Saigon resigned over the first article which, they charged, was written wholly in New York. The cable of resignation of one correspondent, according to a probably inaccurate rumor, ended, "Diem sends love to Clare Boothe and Henry."

Do you remember the articles appearing five or six years ago attacking labor for exorbitant wage demands – demands that would inexorably lead to inflation because they exceeded growth of productivity? Well, the Labor Department hasn't ceased to compile comparative figures in this field but you probably haven't heard about them recently because they show corporate profits way up; wage increases badly lagging. The reason seems simple enough: with continuing unemployment and automation, corporations have labor over a barrel; management is sitting pretty: steady prices, zooming profits and worried labor. No wonder the stock market soars – and probably will, till some day worker's inadequate consuming power fails to buy the goods corporations produce. Here are the figures: In the five-year 1957-62 period, average annual output per man hour in factories rose 3.4 percent; average annual increase in wages and salaries rose only a meager 2.2 percent. For the economy, this is an alarming gap.

Here is another statistic: the ratio of time lost in strikes to time worked was 0.30 percent in the five-year 1951-55 period. But in 1961 and 1962 (latest years available) the ratio averaged only 0.15 percent, or down one-half. Leaders tell me the men hate to strike now, particularly in less skilled trades.

Congressional Calendar

★ At the moment we expect the House will pass a strong civil rights bill about December 1, and send it to the Senate for its supreme test; we guess the South's Christmas gift to the nation will be a filibuster that could decide for a generation whether democracy works. . . . We believe the tax cut will get through, chiefly (and we hate to be cynical) because it is a rich man's bill; only in America could a President as kind to industry as JFK be called "anti-business" – he has given business more tax favors and a better economic climate than Ike did. . . . And to end on a less sour note, here's a story of tangled matrimony in California. Seems two Hollywood boys were arguing and one said, "My dad can lick your dad!" "Don't be silly," retorted the other, "my dad *is* your dad."

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Whither Apollo?

The Kremlin debate about whether to send a man to the moon now seems to be over. For some months – perhaps years – there has been uncertainty and confusion. As recently as October 15 Ambassador Anatoly Dobrynin told American newsmen that a Russian would land on the moon "by the end of the decade." Yet last spring Soviet scientists had told Sir Bernard Lovell that their main objective in space was to build a manned space platform orbiting the earth, and that they had no program for landing a man on the moon. This seemed plausible even then: unlike the moon, a space platform might be valuable militarily – for espionage, for inspecting US satellites, for monitoring nuclear tests or for controlling earth-based missiles. Such a platform would also make a subsequent moon shot both safer and cheaper. Still, nobody in Washington believed Sir Bernard's tale. Early in September, however, academician Anatoly Blagonravov came to Washington to negotiate with NASA on weather satellites. He too reported that the USSR had no counterpart to Project Apollo. Speaking for himself rather than the Kremlin, he suggested a joint moon shot. President Kennedy responded publicly and promptly. But apparently the Soviet military opposed the project as a US "espionage" scheme, and no doubt the economic planners argued that even a joint program would divert men and resources from urgently needed expansion of housing, consumer goods, fertilizer production and irrigation.

This choice vindicates what seemed to many (including the editors of *The New Republic*) a foolish Kennedy decision. In the spring of 1961, in the wake of the Bay of Pigs and Soviet space spectaculars, the Administration sought to recoup some of its lost prestige by devising a space race the US could win. The goal had to be sufficiently remote so that the Soviet's current technological lead would not matter, and sufficiently expensive so that the shortage of manpower and resources in the USSR would make Khrushchev reluctant to compete. The Administration chose a manned flight to the moon, requiring tens of billions of dollars, tens of thousands of engineers, a variety of new technologies and much larger rockets than either side possessed. This strategy worked. Only six years after Sputnik the Soviets have hollered uncle.

Meanwhile, the US has no program for building a manned space platform, much to the regret of most Air Force officers and some scientists. Now that there is no reason to reach the moon by 1970,

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there will be increased pressure to divert NASA's resources to this more modest and more useful project. Other scientists will urge unmanned exploration of the solar system, following the spectacularly successful precedent of last year's Venus probe.

As a practical matter, Congress is almost certain to cut NASA's budget next year and thereby set the target landing date back to 1975 or so. But the extra money is not likely to be spent either on a space platform or on unmanned flights to other planets. Still less will be spent on schools, urban renewal, mass transportation, medicare or unwed mothers, as some liberal Senators have urged. It will simply be "saved," which in the present economic climate really means "wasted." Government expenditures will be cut slightly, consumer demand will sag, unemployment will climb another notch. Senator Byrd and Congressman Mills will hail all this as a triumph for "sound money" and the ideal of a balanced budget. But the only gain will be that a few scientists and engineers may return to academic life or civilian research and development. Hopefully they will contribute more to the quality of American life in such jobs than they now do monitoring astronauts.

Heroes on the Right

On Tuesday morning, October 29, slightly to its own surprise, the Judiciary Committee of the House voted through a compromise Civil Rights Bill which some of its members could hardly have had time to read; and on that Tuesday afternoon, a Republican Congressman, unidentified but representative of the spirit pervading his party's backbenchers, laid an umbrella upon the desk of Minority Leader Charles Halleck.

Both the President and the Attorney General expressed their gratitude for the last minute support of Charles Halleck, with the same awful recognition of the fact of direct divine intervention that pilgrims of the Middle Ages might have felt if, having lain down in the snow and yielded up the ghost, they had seen the approaching curly wolf transformed into a rescuing dog of Saint Bernard.

The hagiography which always grows up around a man who interrupts a life of dedicated malignity with a single act of charity had begun for Charley Halleck. There were stories that he had read the compromise bill and said, "We will take this, because it is what the country needs." Clarence Brown, of Ohio, chief of the Republican corps of sappers on the Rules Committee heard this bit of hagiography and said: "I have known Charley for 30 years and I have never before this heard him say anything about what the country needed."

No more than Clarence Brown would Charles Halleck want it thought that he would so depart from the whole meaning of his life and the core of his nature. He, of all men, would more gladly suffer the indignation of the friends who called him a double-crosser than the gratitude of the hereditary enemies who called him a statesman. There was a more persuasive story that when his old friend Congressman McCulloch of Ohio, had come to him with the compromise, Charley Halleck had read it and rasped: "An FEPC? Whaddaya making me take?"

It is a far stronger bill than the older Republican leadership had ever conceived of accepting, let alone taking responsibility for. Charles Halleck has violated the compact with the Southerners which is the heart of his tactics and has stifled lust at the smell of a bleeding Democrat, which is the innermost response of his natural being.

He has not merely spared the Democrats; he has rescued them. A week before, the Attorney General had seemed hopelessly pulled between the Southern Democrats on the one side and the Northern Democrats on the other. Nearly every Republican of substance in the House was disposed, of course, to sit and watch the Kennedys suffer.

The only exception was McCulloch, the ranking minority member of the Judiciary Committee. McCulloch is a Taft Republican, almost the only complete one left, which means that he is a problem-solver. He wanted a bill and, among all those who wanted a bill, he had the immense advantage of a record of loyalty to Charles Halleck and the right to claim payment of prior debts from him. McCulloch had two choices: he could either sabotage the bill or he could write it. He chose to write it. Last weekend, with scissors and paste, Robert Kennedy's deputies, Nicholas Katzenbach and Burke Marshall, sat the night through in the Congressional Hotel with Robert Kimball, administrative assistant to Congressman Lindsay (R, N.Y.) and William Copenhaver, the Judiciary Committee's minority counsel. Between them, they wrote the compromise, and McCulloch took it and served it up to Charles Halleck and, in the last extraordinary scene in a weekend of unexpected ones, a Democratic Administration was rescued by the least placable Republican partisan still holding a position of strength in Congress.

Whatever dispute about its effect as law may be, the leadership of both parties in Congress now stands behind a bill which declares to be public policy the FEPC, the Powell Amendment, the right of public accommodation and all the other matters, which, however closed in the federal courts, have until now been embarrassingly open and debatable in the legislature. The accident of McCulloch and the accident of Halleck may have brought us that national consensus of all three branches of government for which we have waited so long.

MURRAY KEMPTON

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HEALTH:

Are We the People Getting Our Money's Worth?

Edited by Helen Hill Miller

The United States is alone among industrial nations in not having a publicly-financed health plan to make available to the entire population at least a basic minimum of health care. Yet this country spends not only more, but proportionately more on health than the countries that do have such plans – nearly $6 in every hundred of a gross national product now running at an annual rate of over $588 billion.

On an investment that tops $35 billion, does the American people get its money's worth?

Health is a major national resource; to maintain and improve it, heavy drafts on other resources – physical resources and skilled manpower – are increasingly made. Is the present allocation of resources for medical training, hospitals and equipment, drugs, careers as physicians and nurses wise or wasteful? How could it be improved? Who are the people who get left out of medical care? Who are those who make excessive use of it?

Over the last three decades the patient's relationship to his sources of medical care has greatly altered.

► On fewer and fewer occasions is there a doctor in the house. The general practitioner sees his patients in his office, the clinic, the hospital.

► Of the 170,066 M.D.'s in private practice in 1962, 99,595 were full-time specialists. In some medical schools, the general practitioner's job is taught as a specialty! Rapid multiplication of knowledge gives the practicing physician a problem in keeping up to date: his medical school training becomes partially obsolete almost as soon as he completes it. New institutions are meeting this situation – particularly group practice. In form it ranges from three or four doctors who pool their specialties in a suburban medical center to nationally known clinics, some related to and some independent of general hospitals, that assemble a wide range of the country's highest skills.

► More and more doctors are going into research

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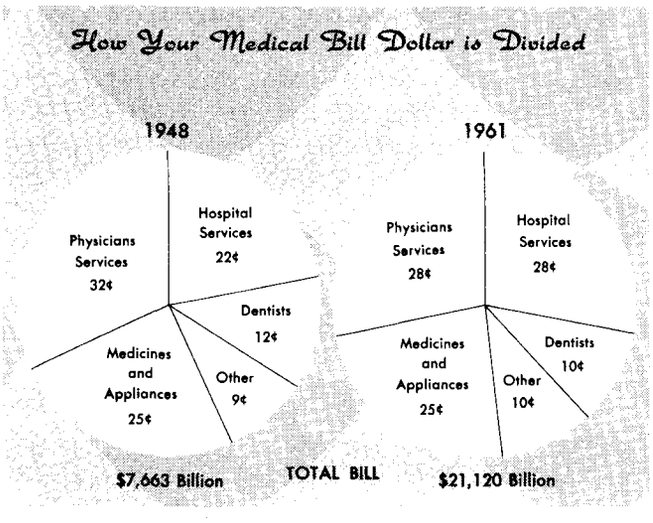
and administration rather than into private practice. Between 1949 and 1962, the total number of M.D.'s increased 28 percent, but the number in research and teaching and preventive medicine went up 233 percent. Since the war, health research has become very big business, with the federal government footing the biggest part of the bill. In 1963, government research expenditures will total about $1.02 billion; another $532 million will come from voluntary health agencies, private foundations and the drug industry, etc.

► Doctors, hospitals and other suppliers of medical care collect a good part of their money in new ways. Doctoring is by no means unprofitable: in 1958, the average net yearly income of the nation's 204,900 active M.D.'s was $16,500. But the old individual fee-for-service, with payment made directly by the patient to his physician or hospital, has been superseded in two ways. In 1929, when the over-all bill for personal health care came to $3.3 billion, patients themselves paid 88 percent of it. Today, other means of payment cover nearly half of a bill that is almost 10 times as large. Many doctors – researchers and practitioners alike – receive salaries from institutions; many others are paid through underwriters with which the patient has insured himself.

► Beginning in the 1930's, non-profit organizations, outstandingly Blue Cross and Blue Shield, enabled American families to pool their risks of medical costs. During and after World War II, most large corporations established group health plans, frequently set up as part of collective-bargaining agreements covering both workers and their dependents; civil servants were generally protected, too. Nearly three Americans in four now have some degree of hospitalization insurance, and almost as many have some degree of surgical insurance. "Major medical" policies, covering combined costs of catastrophic illness, are becoming popular; increasing numbers of Americans also insure against the loss of income that results from idleness due to illness.



► From the early days of the country, the medical care received by members of the military establishment has been organized and supplied under public auspices; this coverage was automatically broadened by the increased size of the armed forces after World War II, and in 1956 it was extended to their dependents by the Medicare program administered by the Army. Veterans entitled to care in government hospitals now number over 22 million.

► Further public funds have increasingly been proposed or applied to provide medical care for other groups such as indigents, migrant farm families and the aged. The free care that indigents obtained in the past through municipal hospitals, private charities or free service by physicians has been supplemented or superseded by payments known as "vendor payments" from public assistance funds to suppliers of medical services; these vary markedly from state to state but now exceed $1 billion annually. A token program for migrants, under the Public Health Service, was initiated in 1962.

Among aged Americans, not quite one in three has any hospital insurance, and less than one in four any surgical insurance. In states participating in the program, the Kerr-Mills Act of 1960 provides hospitalization for aged persons whom a means test proves to be "medically indigent." The King-Anderson Bill now before Congress would provide hospital coverage for elderly citizens without a means test, paid for through the social security system.

Climbing medical costs create problems common to all forms of payment for medical care, public and private. For example Dr. Edward R. Annis, president of the American Medical Association, points out that "today heart operations are very costly. You need so many people. You need engineers to run the heart-lung machines, you need multiple technicians matching and cross-matching 20, 30, 40 pints of blood. You need a half-dozen nurses in the operating room helping a half-dozen doctors including the anesthetist and the rest. This requires a great number of highly trained, highly skilled and expensive personnel, not even counting the doctors, but it's worth it." If benefits are given in the form of services, the continual rise in prices makes the payment of medical bills an open-ended drain, whether on reserves from premiums of private non-profit organizations and insurance companies, on funds obtained through employer-employee contributions, or on public budgets. If limitations are put on extent of benefits – up to x days of hospitalization or y dollars of doctor bills, the patient is penalized by reduced coverage. If participation in plans is limited by leaving out the costlier risks, the burden on those who cannot get coverage becomes doubly onerous.

Public and private plans likewise share the problem

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of the chiseler. What should be done about patients who prolong their stays in costly hospital rooms because they have insurance or other forms of entitlement? About doctors who regularly charge the maximum on agreed fee scales? About drug firms that supply wonder drugs at wonderful prices?

In this study, *The New Republic* has brought together pertinent recent findings on the nation's health care, and invited experts to state their views on some of the more controversial issues concerning its maintenance and improvement.

Economics of the Nation's Health

Since 1900, the life expectancy of a child born in the United States has risen by a quarter of a century. Fewer people are cut off in their prime by, say, TB or pneumonia, or stricken before their first birthday by such former childhood killers as diphtheria. The vitality of today's population is not sapped as it was 60 years ago by massive infection from malaria or typhoid fever. The cardiovascular ailments which figure so often in today's obituaries are for the most part terminal diseases of men and women who have had an opportunity to live out a full and generally healthy life.

In terms of individual well-being, of release from acute pain or nagging disability, recent gains are immeasurable. In terms of the nation's economy they can be measured – more man-hours worked, augmented national product, additional income enjoyed.

Rashi Fein, *now of The Brookings Institution and until recently on the staff of the President's Council of Economic Advisers, estimates the additions to the nation's wealth due to improvements in life and health during this century, and describes the losses due to mortality and morbidity that still persist.*

William McKinley had just been elected President; Arizona, New Mexico and Oklahoma were not yet part of the Union; the population of the 45 states was 76 million and the gross national product about $17 billion. It was 1900 and the white male born that year had a life expectancy of 47 years – he could hope to see the second half of the century, but neither he, nor, for that matter, his sister could expect to. If the child was non-white, his life expectancy was only 33 years, and barely sufficient to bring him to the first hundred days of the New Deal.

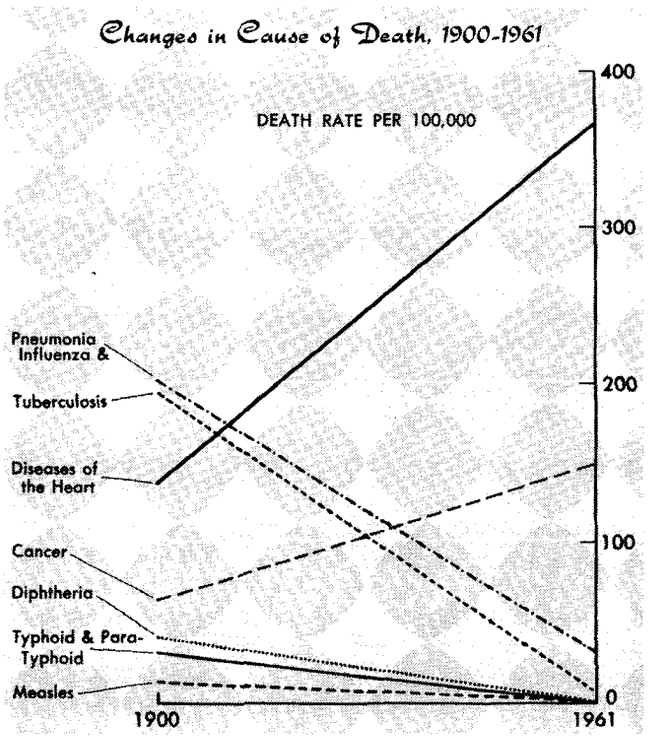
The years of productive contribution that the nation could count on from its population were still more limited, even though in those days youngsters began work earlier: the expectation of working life for the white male born when McKinley entered office was 31 years; for the non-white, 21 years.

By contrast, the white male born in 1960 had a life expectancy at birth of 67 years, a gain of 20 years in six decades. His sister had gained even more: some 25 years. For the non-white male, life expectancy at birth was 61 years – 91 percent of that of his white counterpart. Investments in education and training, now normally continued at least through high school, had longer pay-out periods in which to prove themselves profitable: working-life expectancies had risen to about 43 years for whites and 38 years for non-whites.

These advances in life expectancies, and the rising levels of health with which they are associated, increased both the size of the labor force and its effectiveness on the job. Dr. Selma Mushkin has estimated that of the 67 million persons employed in 1960, 13 million survived to that time because of the decline in death rates since 1900. She concludes that over 10 percent of US economic growth in the last half century is attributable to the increases in the size of the labor force due to this cause. The labor product of these people added more than $60 billion to national income in the one year, 1960.

The decline in death rates that new knowledge has made possible are spectacular. Over-all, the death rate, adjusted for age, dropped from 17.8 per 1,000 population in 1900 to 7.7 in 1960.

Americans are living longer, but illness still cuts



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down their efficiency. On an average day in 1962, almost two of every hundred currently employed persons in the civilian population were absent from work because of illness, injury, impairment or chronic disease. For the entire year, 394 million work days – almost 6 days per worker – were lost for these reasons. That is more than the total days lost because of industrial disputes in the 12 years 1950 through 1961. Reduction of only 5 percent in the number of work days lost because of illness would add as much to the nation's productive force each year as has been lost in recent years because of strikes and lockouts. Three-hundred-ninety-four million days is 1.5 million man years, more than all the man years that are currently worked in Ireland, Israel or Norway. Put another way, the loss is as great as if the wheels of the whole US economy ground to a dead stop and stayed idle for more than a week.

True, such figures may overstate losses of production due to illness in cases where lost time is made up by overtime later, or in cases where an ounce of prevention obviates need for a pound of cure. But they understate the impact of illness on production by not including some 300,000 people in institutions who would have been in the labor force if not physically or mentally ill, and perhaps an equal number of non-institutionalized persons who are out because of chronic sickness. They do not measure the reduced effectiveness of those who are ill but not absent from work, or of absences of less than an entire day. They do not take account of the fact that chronic illness limits 3.4 million persons in the amount or kind of work they can perform.

Better health would not only increase national production; the resulting reductions in treatment costs would free resources currently employed in a particular health area for use in other ways. The state of New York, for example, has estimated that changes in rates of admissions and discharges to New York State mental hospitals in the latter 1950's resulted in a saving of $180 million in costs of care and construction in 1959.

But the economic dimension of health cannot be measured by the costs of treatment alone, nor can the benefits of better health be estimated by reference only to the savings in treatment and prevention costs. Loss of income and the production it represents are just as much part of the bill. Dr. Burton Weisbrod has calculated the treatment costs of cancer at $350 million, and the total cost of the disease, including lost earnings and the impact of cancer mortality, at about $2.5 billion. Tuberculosis causes a loss of perhaps $750 million, of which about half represents treatment costs. I have estimated that in 1952, the earnings lost by patients resident in mental institutions were about $700 million.

The health dollar needs to be recognized as in part a consumption expenditure, since health, like education, is something people would willingly pay for whether or not it made any economic contribution. But

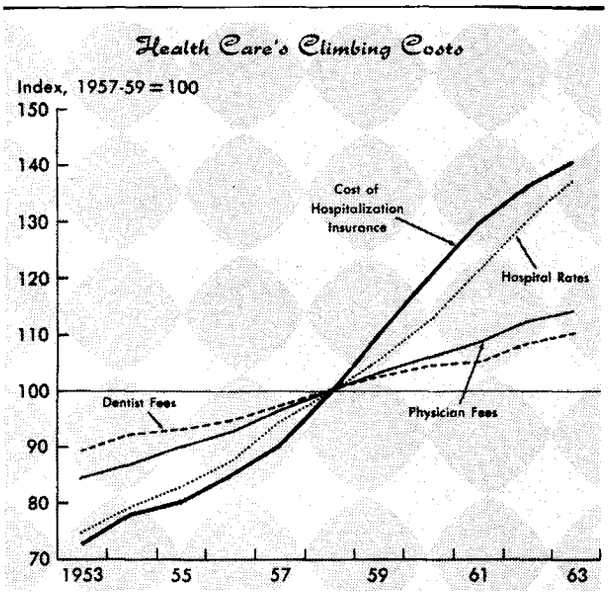
CLIMBING COSTS

In telling all about his operation, the recuperating patient who buttonholes a listener will not omit an itemized enumeration of its costs, including what he paid for prescriptions to be taken after going home. The average citizen's acute consciousness of the high price of health can also be documented, and with greater accuracy, in other ways.

Almost 4.5 million taxpayers sought relief by reporting medical expenses on their 1960 returns: their allowable deductions amounted to nearly $5.5 billion of unreimbursed expenses totaling over $8.5 billion. Of the taxpayers making these returns, 1.8 million had incomes under $5,000; 2.3 million had incomes between $5,000 and $10,000.

Again, Department of Commerce figures on the allocation of personal consumption expenditures show that over the past 10 years, the slice of their incomes that Americans gave to medical care has widened by 33 percent. This represents increased use of medical facilities, but also reflects higher costs of services used.

Recent price rises show up startingly in the monthly Consumer's Price Index compiled by the Bureau of Labor Statistics. In the 176 months between January, 1947, and September, 1961, medical care prices went up 164 times. On its new base of 1957-59=100, by June, 1963, the index as a whole had gone up to 106.6; its service components had gone up faster than any others to 111.3; and among services, medical care services at 120.0 led all the rest. The rates of climb of the various elements in medical care are most striking of all.



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in discussions of national policies – both those directly related to health and such indirectly related programs as housing, education and full employment – and in discussions of expenditures for public health and medical research, where "what can we afford" is one criterion, some portion of the health dollar should be recognized as an investment. Prevention of 100 premature deaths or long-term illnesses may add resources with a present value of $5 million to the economy. Improving the Nation's health is thus investment in human capital; it adds to productive potential; it creates the possibility of more consumption tomorrow. That there is still room for much profitable investment of this sort is abundantly clear from the data presented above, from comparison of white and non-white differentials in the United States, and even from comparisons of US levels of health with those of other countries.

Rashi Fein

Whadda Ya Mean, Hospital?

Actually, the prices of medical care in the Consumer's Price Index lump horses and apples. Today's hospital and yesterday's hospital are both called hospitals, but otherwise the resemblance is coincidental.

To mention some contemporary spectaculars among mechanical inventions now common in major institutions but unknown only a few years ago, the price of a cobalt bomb for cancer treatment ranges from $40,000 to $150,000, and the construction required to house it runs from $15,000 to $60,000 more.

A good X-ray machine for routine diagnostic purposes costs $25,000. Equipment for specialized purposes comes higher; $150,000 for angiography if the machine has image intensification and a TV attachment; $70,000 for urology, $65,000 for the GI tract. Installation costs $10,000-$20,000 for each.

Surgery such as the transplantation of organs was not performed in any hospital as recently as the end of World War II. Years of medical training for surgeons and physicians and their supporting technicians have lengthened accordingly. The number of persons who must be in the operating room at the time of such an operation is high.

It's a long way from a cobweb to penicillin, from an asafetida bag to psychotropic drugs for schizophrenia.

Underlying the spectaculars are more familiar changes – increases in building costs (air conditioning is a new item and the number of square feet per bed is greater than it used to be); new levels of wages and salaries (they are still low) due to unionization and shortages of personnel.

Herbert E. Klarman, *associate professor of public health administration and political economy at The Johns Hopkins University, former associate director of the Hospital Council of Greater New York and author of* Hospital Care in New York City, *describes the structure of the modern hospital.*

There are almost 7,000 hospitals in this country, with 1.7 million beds. They admit 25.5 million inpatients, employ 1.7 million persons, and spend $9.5 billion a year.

The modern hospital ranks among the foremost

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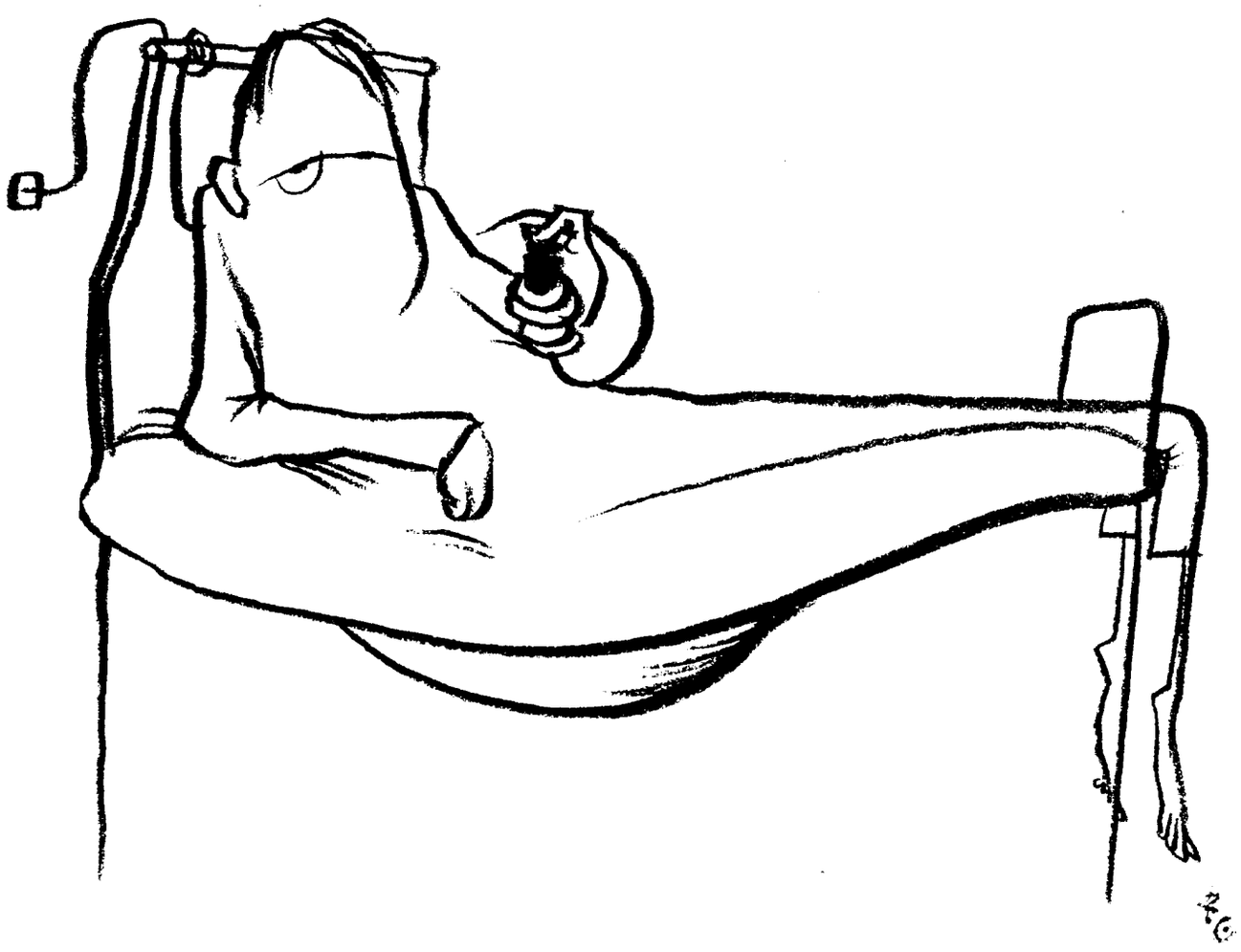

achievements of the 20th Century. It is, as Ray Brown, vice president for administration, University of Chicago, and former Superintendent of the University's clinics and hospitals, has defined it, "the community's centralized facilities for medical care. It represents a cooperative effort whereby the total community has pooled its resources in order to provide the sort of specialized equipment and highly-trained personnel that no patient or doctor could provide individually, and which no patient could afford to use and maintain by himself."

Uppermost in the public mind are the 5,700 short-term hospitals. With 44 percent of the beds, they admit 94 percent of all inpatients, provide almost all of the outpatient and emergency services rendered by hospitals, and account for 74 percent of the annual expenditures.

Among the short-term hospitals the general hospital is gaining at the expense of such specialty hospitals as maternity, orthopedic, or eye and ear. This trend is in accord with current thinking, which stresses the flexibility of the general hospital, as well as its climate favoring the interchange of ideas and consultation among physicians.

Most general hospitals today are concerned with the treatment of short-term inpatients with acute illness. Care of long-term patients with chronic diseases, of ambulatory patients, or of patients at home is secondary in their list of priorities. Few general hospitals assume responsibility for the medical care received by aged persons in nursing homes or in the infirmaries of homes for the aged. Inpatient care of psychiatric patients remains predominantly the function of state mental hospitals. In the general hospital, all major and most minor surgery is performed; almost all deliveries; much diagnosis, especially on inpatients; considerable medical treatment that requires either daily attention by the physician or regular nursing care; and an increasing proportion of all emergency services rendered by physicians. Here, too, the most costly medical bills are incurred, and the battle is fought over access of physicians to a good part of their livelihood, their professional growth, and the future form of organization of medical practice.

Unlike hospitals for long-term patients, which are mostly owned and largely financed by government,

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general and other short-term hospitals are mostly under private, voluntary (non-profit) ownership and are financed by funds from a variety of sources. Thus voluntary hospitals own 63 percent of all short-term beds and admit more than 70 percent of the patients. (By contrast, private proprietary [for profit] hospitals own 5 percent of the beds and admit 6 percent of the patients.) My estimates of the sources of funds of short-term hospitals are as follows: public funds, one-fourth, including 3 percent from philanthropy; and private payments, three-fourths, including one-half from health insurance benefits.

The key personnel of American general hospitals, the physicians, are usually not employees. Neither do they serve on their boards of trustees. They are private practitioners who use the social capital embodied in the hospital's facilities and, in return, provide free care to some of its patients and participate in teaching medical students and house staff (interns and residents). In theory, total responsibility for the operation of the hospital, including the quality of its medical care, vests in the board of trustees. In fact, while the physicians practicing in the hospital ostensibly play no part in formulating policy, their authority in the internal operation of the institution is unchallenged. It is they who make most of the decisions regarding the appointment of physicians to the staff, as well as many of the decisions that influence the cost of operating the hospital.

Since the board of trustees of a voluntary hospital has full discretion to approve or reject an application for appointment to the medical staff, considerations other than professional qualifications may enter into the decision. Unethical practitioners are denied appointment. Non-conformists may be punished. Competition may be curtailed.

Instances are known in which the fight against prepaid group practice plans has taken the form of denying regular hospital staff appointments to their physicians. Examples of denial of regular hospital staff appointments to physicians associated with group practice plans are: the Health Insurance Plan of Greater New York (HIP) and the voluntary hospitals on Staten Island in New York City; the Bellaire Clinic and Bellaire City Hospital in Bellaire, Ohio (the latter is also a voluntary hospital). Negro physicians are often deprived of their share of staff appointments in hospitals serving the entire community.

Even if the sole criterion for physicians' staff appointments were professional competence, the interests of the hospital and of the community can diverge. A hospital wishes to have as highly qualified a staff as possible, and frequently tries to appoint only certified specialists. A community is concerned in addition about the performance outside the hospital of the practicing physicians of the area, and may place a high value on the educational benefits that such physicians derive from participating in hospital activities.

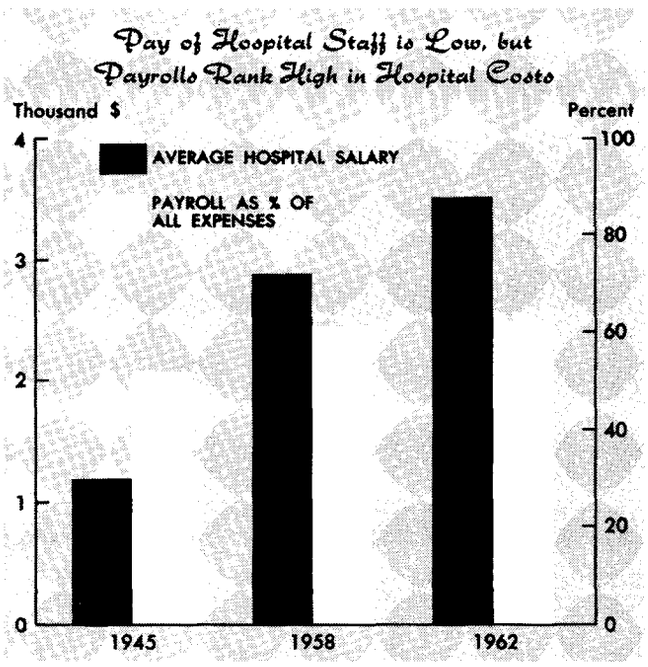
In the postwar period the unit (patient day) cost of hospital care has continued to rise at an annual rate of 7 to 8 percent. Why?

Fifteen years ago it was thought that hospital costs would stabilize after this industry, which then paid notably low wages to hospital personnel, had succeeded in catching up with the wages and working conditions of other industries.

The work week of the registered nurse declined from 48 hours in 1941 to 44 hours in 1949. Between 1940 and 1949 the monthly salary of the staff nurse rose from $105 to $205. Vacations with pay lengthened and the split shift was substantially eliminated. Participation in social security became available to employees of nonprofit agencies in 1950.

Subsequently, emphasis was placed on the costliness of medical progress. It takes about $20,000 to equip an operating room in today's hospital; an electronic microscope costs between $15,000 and $35,000, an auto analyzer in the laboratory $6,000 to $8,000. Associated with most of these items of equipment is a large expenditure for skilled personnel to operate and maintain them. Conversely, it should be noted that a good part of the recent reduction in lengths of stay is costless.

Most recently, it has become evident that still another major factor is the lag of all personal service occupations behind the gains in productivity of the economy at large. Educational programs have also come to be an item of net cost to the hospital.



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Hospitals have attempted to adjust to the lag in productivity – and to perpetual shortages of personnel – by employing more part-time workers and less skilled workers to perform the lower-skilled jobs of nurses' aides and orderlies. But such adjustments result in the fragmentation of care, and require increasing supervision. It may well be both more efficient and more effective to hire skilled persons who require little supervision, and can render continuous service to a patient. The findings of operations research in hospital management suggest that where the arrival of patients and their service requirements cannot be scheduled, the most efficient way to organize is to have the several elements of a service performed in one place by one person with diverse skills. A recent Roper poll in the New York area suggests that the public would agree: respondents indicated that they are impressed quite favorably with the scientific aspects of modern hospital care but not so favorably with the personal service received in hospitals.

Today's enlarged hospital bills do not even reflect some of the increased costs of care in hospital. Anesthesia is now performed not by hospital employees but by independent practitioners. Private duty nurses are not on the hospital payroll, and their cost is seldom covered by hospital care insurance.

Students of hospital economics see no likely ways to achieve reductions in unit cost. Quite the contrary is probable: wages of employees are being raised in response to unionization drives and stipends for house staff are increasing.

An effort to control expenditures for hospital care is being made by limiting hospital use to those who have actual need of this level of service. One way to do this is to broaden the types of benefits covered by health insurance so that patients do not come to hospitals for care that can be given elsewhere. Another is to expand nursing home facilities so that patients can move out as soon as they no longer need the costly facilities of the hospital, and recuperate elsewhere. Some community health insurance plans support home care services as a means of reducing their premium costs.

Above all, overuse of facilities can be controlled by limiting the supply of hospital beds. In the days when vacant beds were a primary risk, each institution faced a financial deterrent to over-building, since a large fraction of hospital cost – three-fourths – is fixed and does not vary with patient census. But today, too many hospital beds are occupied by patients whose requirements could be adequately met by much simpler arrangements and much smaller drafts on community capital and skilled manpower, but whose insurance entitlement is limited to use of these high cost facilities. Their presence unnecessarily increases the costs of medical care; the financial interests of the individual hospital and of the community as a whole may no longer coincide.

Pressure is accumulating to control the supply of beds through coordinated area-wide planning. But there are certain obstacles to achieving the degree of cooperation among hospitals that would be required. First, voluntary activity is by its nature local, not readily transferable geographically. Second, there are differences in type of program and in the characteristics of patients cared for, so that hospitals are not interchangeable. Third, hospitals with major teaching programs find it necessary to exercise selectivity in admitting patients. Finally, physicians are opposed to losing their patients: area coordination would require selective duplication of physicians' staff appointments among hospitals.

HERBERT E. KLARMAN

So You Need a Nurse

In 1962, there were slightly over a million Registered Nurses in the country, but only half of them were practicing. Some of those not practicing are married and bringing up young families, but many are deterred by the fact that they can make much more doing something else: in the latter 1950's, teachers in urban public schools earned a median income of $5,000; hospital staff nurses, $3,900. The high turnover that accompanies all low-paid jobs holds in hospitals: in 51 general hospitals in 1955, the turnover of staff nurses ran at nearly 60 percent a year. Yet with increasing demands for health care, the need for nurses goes up, particularly for those whose training prepares them to be supervisors, administrators, teachers, and clinical specialists.

Today, the skills of professional nursing are spread thin; in perhaps no other profession has a more far-reaching effort been made to increase the productivity of the highly skilled by training auxiliary staff aides and orderlies to do the less skilled parts of a professional's job. In general hospitals, only about 30 percent of the direct nursing service is given by professional nurses; the 719,000 patients in psychiatric hospitals receive less than 10 percent of their care from persons with such training.

Admissions to nurse's training in proportion to the number of 17-year-old girls fell from 40 per 1,000 in 1955-56 to 34 per 1,000 in 1960-61. The Surgeon General's Consultant Group on Nursing, estimating the country's need for professional nurses in practice at 850,000 by 1970, has suggested measures which, taken now, could produce up to 680,000. Continuance of present trends and present levels of economic incentive will probably not provide more than 650,000.

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Medic! (Did Someone Cry Wolf?)

Just after demobilization, veterans' pressure for admission to medical schools allowed wide choice among applicants and favored the upgrading of medical quality. Then came a drop-off. Was it because possible entrants were allergic to nocturnal telephone calls or because financial rewards or intellectual interest – or both – were greater in other scientific areas? The number of medical school applicants, 16,763 in 1952-53, reached 15,000 only twice within the ensuing decade. Further, while the number of those who secured admission and survived to graduate rose from 6,135 in 1950 to 7,168 in 1961-62, more and more of them have been going into research rather than into private practice.

Over the country, the distribution of physicians is such that the ratio of doctors to people varies considerably. In 1959, the Northeast had a doctor for every 848 civilians, the South one for every 1,345. Northeastern doctors averaged 4,400 patient visits a year as against 6,200 in the South.

In addition to variations in availability of medical care are variations in its use according to income, to years of education of the head of the family, and to race (whites average 5.2 physicians visits a year as against 3.5 for non-whites). Rising incomes and a growing appreciation of the desirability of regular and preventive medical and dental care, especially among minority groups, point to new demands for health services over and above those to be expected from a rising population.

Accordingly, concern over future doctor shortages has been expressed in a series of surveys, of which the Bane Report, prepared for the US Surgeon General in 1959 by the Consultant Group on Medical Education, is the most recent. It foresees a shortage of physicians amounting to perhaps 18,000 by 1975. Accordingly, incentives to enter medicine are being offered in the form of federal grants under the National Defense Education Act and loans – in 1963 Congress authorized substantial additions to the loan programs. Such aid helps offset costs of medical training and income foregone during years of internship, residency and postgraduate work by those who choose this profession.

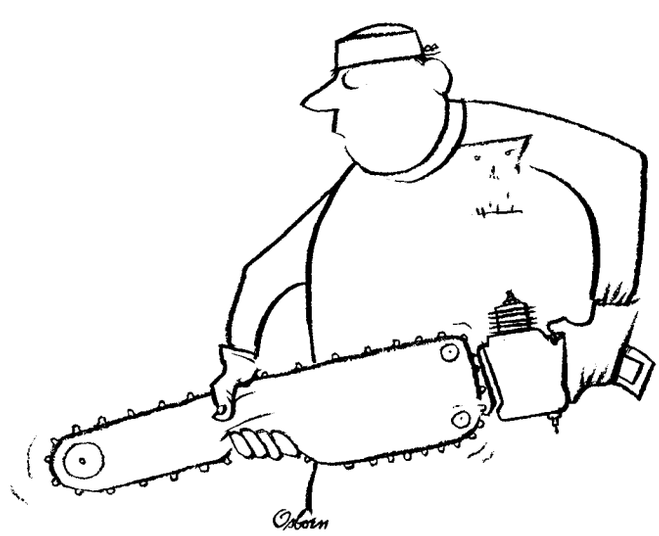
On the other hand, the skills of the numbers of doctors actually available could be used more efficiently.

Because the emphasis on government and other action to meet the anticipated physician shortage has been conspicuous and continuous, The New Republic *here presents another point of view. The authority is* W. Lee Hansen, *currently in transition from the Department of Economics at UCLA to the staff of the Council of Economic Advisers in Washington; he questions the need for more government-offered incentives, believing that the law of supply and demand, plus revised (and shortened) curricula in medical schools and increased productivity per physician will probably produce all the doctors that the country needs.*

Is the evidence for a future physician shortage clear-cut? Concluding that a growing shortage can be expected in the coming decade, the Bane Report to the Surgeon General in 1959 recommended an offsetting program of additional government loans and grants to medical students; construction of medical schools in states not having them and expansion of existing schools; allocation of additional research monies; and reexamination of the medical school curriculum to speed up training. The authors of the Report arrive at their shortage estimates after affirming that the need for physicians' services depends upon four factors: population growth; population age structure (the old and young require more care); rising per capita demand for medical care; and the proportion of physicians currently going into private practice (this proportion has fallen).

On the basis of projected changes in these variables, the need for physicians' services will clearly increase by 1975. But is it correct to assume, as the Bane Report does, that the number of physicians must grow at the same rate as the population, that the physician-population ratio of 141 per 100,000 which prevailed in 1959 must be maintained?

Over recent years, impressive productivity increases have occurred in the medical profession. One estimate places the increase from 1940 to 1950 at one-third, and in the 1950's it appears that comparable gains may have been achieved. These gains stem from increased special-



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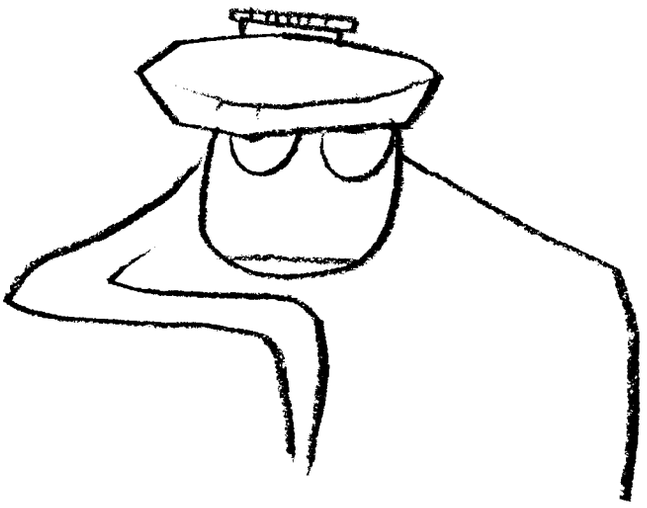

ization and the development of group and clinic practice; diversion of more physicians into research and related fields, thereby speeding up the rate of discovery of new medical knowledge, new treatments and new drugs; and rapid expansion of the paramedical professions (nurses, technicians, and the like). Productivity increases of recent magnitudes can offset partially if not completely the need for rising numbers of physicians. It should not be forgotten that as recently as a decade ago, another report forecast substantial shortages by the year 1960 unless certain steps were taken to create more medical schools and to increase the number of medical students. The steps actually taken were very limited, yet in 1960 concern about a current shortage of physicians was far from widespread – indeed, by using the 1959 physician-population ratio to project future needs, the Bane Report implicitly assumed that ratio to be adequate.

The problem that plagues the projection of physician needs, and of manpower needs more generally, is the almost blind reliance on simple physician-population ratios. California currently boasts a physician-population ratio of about 175 per 100,000. Since it wants to maintain this ratio, it claims to need a significant expansion of medical school facilities in the state. Similarly, states such as the Dakotas, Mississippi and Alabama, with ratios of 70-80 per 100,000, can justify development of added facilities as a way to bring themselves up to the national level of 141 per 100,000. But if any thoughtful basis for justification of a "proper" ratio – is it 75, or 141, or 175 – is lacking, and if such efforts succeed in a substantial number of states, US facilities for producing physicians would be enormous.

The numbers who actually enter the medical profession over the next decade will undoubtedly reflect the economic costs and returns to people choosing medical careers as against alternative careers. Although some people would prefer to be physicians regardless of the money return from their profession, others will be more sensitive to the costs of training they must incur and the salary levels they can expect afterwards.

In the popular mind, high earnings by physicians appear to result from the profession's control over entry; the smaller the number of students, the fewer the doctors turned out and the higher the earnings of those who do become M.D.'s. In fact, the higher incomes of physicians as compared to the average college graduate represent primarily a form of compensation for the long period of costs and income foregone while in training. However, the present relationship between costs and returns in medicine relative to other professional occupations is still favorable enough to continue to lure people into medicine, and if and when a shortage of physicians begins to materialize, salaries will rise and a medical career will become even more attractive. In this sense, shortages will be largely self-correcting through the market mechanism, though this approach may be considered reprehensible by those who feel that greater financial returns will attract other than "dedicated" people into the profession and thus debase it.

Traditionally, the medical profession has had almost first choice among the most talented young people, but as activity in the scientific fields mushrooms, this no longer seems to be true. It is easy to lament the apparent decline in the numbers and quality of medical school applications, but quality can be maintained only at some cost. Whether the American people wish to incur this cost at the expense of other presumably important activities remains to be seen.

Admittedly, medical school facilities are currently inadequate for an expansion of enrollments such as might occur in response to the development of a market-type shortage. Either added facilities must be built in expectation of shortage conditions or the curriculum must be capable of modification so as to accommodate more students in existing facilities. One convenient method of turning out more doctors in existing facilities is to shorten the training period. The Johns Hopkins and several other institutions are currently doing so. When simply shortening the length of training reduces costs and thus makes medicine more attractive, grants in the form of federal subsidies to medical students, as advocated by the Bane Report, appear inadvisable: acceleration accomplishes the same result as does a grant and is significantly cheaper. Society already heavily subsidizes medical students; their tuition and fees represent only a small fraction of the cost of training them. Since physicians appear to be earning an excess on their own investment in training relative to that of most other professionals, the economic arguments for further increasing this excess through federal subsidies are weak.

W. Lee Hansen

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Is This Operation Necessary?

The average American is awed by modern medicine. He avidly reads about wonder drugs, miracle operations, unbelievable recoveries. When antibiotics reduce his temperature by five degrees overnight, his reaction contains more of superstition than of science. Yet he still hesitates wholeheartedly to offer a cock to Asclepius. The tag, "government officials classify their mistakes, but doctors bury theirs," haunts his memory. And if some of his best friends are doctors, he will not be at a loss for documentation.

One way to check on doctors' performances, particularly the work they do in hospitals, is to have regular audits made by outside physicians who compare results obtained over a given period with objective standards; the auditors' check would indicate where practice was faulty, and where unnecessary treatment was undertaken. Such audits are made in a number of areas.

Paul A. Lembcke, M.D., M.P.H., professor of public health and preventive medicine at UCLA's School of Public Health and School of Medicine, discusses this means of control of medical quality.

Significant moves toward better quality of medical care stem from a great improvement in undergraduate medical education that began in the US after 1910, and a tremendous increase since 1945 of graduate training in the medical specialties. (Over 70 percent of recent graduates spend three to five extra years to become fully qualified specialists.) Education in other fields has made contributions also, as has the hospital accreditation program conducted from 1919 to 1952 by the American College of Surgeons and since then by the Joint Commission on Accreditation of Hospitals. On the other hand, postgraduate or continuing medical education has unfortunately been functioning considerably below the level required to keep doctors' skills and knowledge up to date.

One approach to the problem of providing good medical care is found in the Veterans Administration, where the employment of salaried physicians removes any financial incentive to perform unnecessary surgery, and the supervision of medical work by a "dean's committee" of a medical school and the employment of medical school faculty as part-time consultants facilitates continuing education and helps to elevate the quality of medical care. Opportunities are also offered for research and teaching. Non-governmental organizations, mostly consumer or labor-union sponsored, have also sought to reduce unnecessary surgery and hospitalization and enhance the quality of care by arranging for physicians to be paid on a salary or salary plus profit-sharing basis. But such plans have had only a limited appeal to either physicians or patients and seem unlikely to become the prevailing form of medical practice in the US for some years, if ever. To promote a good quality of medical care for the people generally there is therefore great need for a system of quality control that can be applied to all forms of medical practice, especially fee-for-service practice. Medical auditing can supply such control.

The need for it is clear. My work leads me to estimate that preventable deaths due to surgery, cancer cases excluded, number some 9,000 annually in US hospitals. (Gall bladder surgery alone is responsible for at least 5,000 preventable deaths on the basis of an average case fatality of one percent in a university teaching hospital in the period 1943-53, while 10 years later community hospitals, even those having interns and residents and a favorable selection of patients, had fatality rates of two percent and higher.) Also, some 12,000 preventable deaths occur in premature infants. Other preventable deaths result from failure to control hemmorrhage, delay in commencing treatment in a variety of emergency cases such as heart attacks and injuries, and the improper use of drugs – too little, too much, or the wrong kind. Altogether there are probably 30,000 preventable deaths per year in the US.

The criteria used in medical auditing should be correlated positively with prolongation of life and the relief of disability or its prevention. Standards can be determined by reference to experience in university

Quis Custodiet Custodes?

Who should set standards for medical practice and how should they be applied? Under what conditions is it possible to provide medical care that is satisfactory to the consumer and the provider, without unnecessary use of doctors, drugs and hospitals? Can the economies of salaried medical practice be obtained without sacrificing the rapport of fee-for-service? Do salaried systems provide all the care that is needed, or only minimal care? Is the fee-for-service system of paying physicians wasteful or not? Is it possible to organize facilities and distribute patients so that medical practice everywhere will approximate the quality attained in university teaching hospitals? By what means should the education of doctors be continued through the years after medical school, internship and medical specialty training, so that the doctor can keep abreast of new developments in medicine?

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teaching hospitals, where medical practice is close to the sources of research and education, and where the lowest death rates and the highest rates of cures are found.

Few standards should be set as high as 100 percent, in view of individual variations in the manifestation of disease in the patient and their interpretation by the doctor. Thus a standard for hysterectomy may require that only 85 percent of operations be justified by the medical audit criteria – the other 15 percent represents the exercise of clinical judgment. Each physician's work, however, should meet the 85 percent standard over a period of time; it is not acceptable for some doctors to have records consistently below standard.

As a rule, surgical cases are most easily evaluated. Ninety-five percent of operations for the removal of a ruptured intervertebral disc should be justified by preoperative X-ray showing the pressure of the disc on the spinal cord or nerve roots, and at least 75 percent of operations done primarily for removal of the appendix should be justified by the finding of significant inflammation on examination by a pathologist.

The sins of commission rank high in the average nonteaching hospital. In such institutions, justification for the appendectomies performed runs 20 to 30 percentage points below university teaching hospital standards.

Hysterectomies are below by 20 to 40 points, obsolete operations like uterine suspension fall short by 80 to 100 percentage points, tonsillectomies by perhaps 75 to 85 points. It has been reported that 50 percent of heart surgery is unjustified. In obstetrics the evaluation should take into account the incidence of maternal hemorrhage, tearing of the uterus or tissues of the birth canal, unnecessary pelvic X-rays, premature birth, the survival of the infant and its condition.

In medical cases, the criteria of proper and successful diagnosis and treatment vary with the disease. A series of pneumonia cases may be judged principally as to quality of diagnosis – what proportion have had confirmatory X-ray diagnosis of pneumonia, and quality of treatment – bacteriological identification from cultures of blood and sputum or of throat washings, and proper dosage with the indicated antibiotic. In medical cases generally, diagnostic accuracy is perhaps 10 to 15 percentage points below that at the university teaching hospitals, and excellence of treatment is 20 to 25 points below.

Largely because most medical auditing is done by members of a hospital's medical staff, employing criteria and standards mainly of their own devising, not everyone would concur in the above statements regarding quality in medical care. Self-appraisal reveals few faults. Ideally, a hospital medical staff should make a continuous audit of its own, subject to two conditions: first, written criteria and standards from an authoritative source should be employed; and second, the results should be checked periodically through an external audit by a qualified physician from outside, or by an accreditation agency. Unfortunately, very few hospitals meet either of these conditions, least of all the first.

Since only 170,000 beds, 10 percent of the US total, are in the 234 hospitals having a major affiliation with one of the 84 US medical schools, the question can be raised as to whether the university teaching hospitals set an impossibly high standard for the other 6,680 hospitals. But the alternative of having lower permissible standards for small hospitals and for rural areas would not be suitable for the vital matters dealt with in hospitals.

Neither is it wise to take for granted the quality of a specialist's care. The qualified medical specialist can be counted on for good technical performance, but the volume of his work may be influenced by financial incentives. In one hospital audit it was found that when an all-specialist medical staff was paid salaries, the gynecologists did about 26 hysterectomies per audit period, but later, on a fee-for-service basis, they did 130 per audit period. Perhaps too few hysterectomies were done when the surgeons had no financial incentive, but many of the large number done later could definitely not be justified by generally accepted standards. Also in

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this hospital there were several instances of ruptured or torn uterus as a probable consequence of drugs used to speed up childbirth. In other specialty fields, however, the medical care of this institution compared favorably with the standards derived from university teaching hospitals.

One of the most effective means by which the problem of substandard care can be solved is through regional organizations that develop and coordinate a full range of medical care services and facilities, promote their efficiency and make them reasonably accessible to every resident. Educational programs are developed and coordinated at undergraduate, graduate and particularly continuation or postgraduate educational levels for the professional persons who furnish medical and hospital services. By these means a region can be so organized that the net effect is that of a single large hospital, all portions of which, even though 100 or 200 miles distant from the center, are effectively affiliated with a medical school and other sources of professional education. In one such program, that of the Rochester (N.Y.) Regional Hospital Council, 60 percent of the budget was spent on continuing education of doctors and other professional persons, 20 percent on advisory services, and the remainder on the origination and coordination of blood bank, X-ray and laboratory services, medical auditing, regional planning and hospital design, and administrative research. The cost of the entire "package" was less than two percent of the hospitals' operating expenses.

PAUL A. LEMBCKE

Hedging the Great Gamble

In a given year, the health bills of 54 American families in 100 will take less than five percent of their incomes. But for one family, medical expenses may take as much as half the entire year's income or even wipe it out altogether. No one can tell which family will be which: with a little bit of luck and strong constitutions your family may not be hard hit this year. But next year?

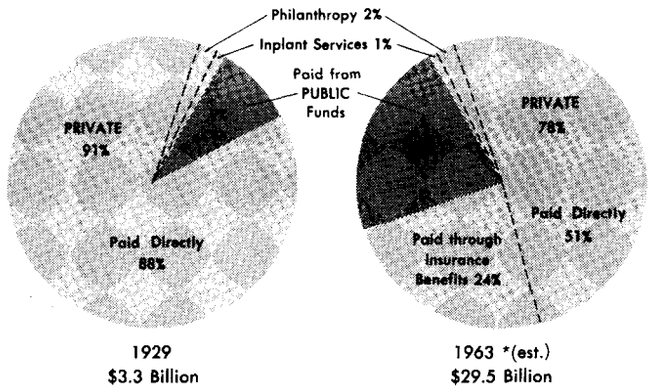
Over the past generation, most Americans who could do so have increasingly hedged their bets. In 1962, Blue Cross and Blue Shield's collections were $3.119 billion in premiums; insurance companies', $3.964 billion; and other plans', $483 million. Of these sums the amounts retained for administrative expenses including selling costs, premium taxes, additions to reserves, and in the case of the insurance companies, profits, were $225 million for the "Blues," $791 million for the insurance companies, and $44 million for other plans; the rest was paid out in benefits.

Some four-fifths of the families with incomes over $4,000 and about a third of those with incomes under $2,000 now have some degree of protection against hospital expenses. Coverage of surgical costs has become comparably widespread; some families have insured against medical and drug bills as well. Only just over half of all medical bills are now settled directly by patients.

At the same time, expenditures of public funds for personal health care have also expanded.

IDA C. MERRIAM, *director of research and statistics of the Social Security Administration, analyzes recent changes in ways of covering health costs.*

Sources of Payment for Personal Health Care



In 1929, expenditures for personal health care averaged $27 per person, and 88 percent of the bills were handled through direct payments by consumers to providers of service. A little under three percent were taken care of by philanthropy and industrial on-the-job services, the remaining 9 percent by public funds.

In fiscal 1963, these expenditures averaged $157 per person; direct consumer payments covered just over half the total cost of personal health care; insurance benefits, 24 percent; public funds, 22 percent. With the increase in size of the average bill has come a change in its composition. The share of the health dollar going for hospital services was something less than 10 percent in 1929. It had become 36 percent by 1961.

The present pattern of payment for hospital care likewise represents a major change distinguishing it from the financing of other parts of the medical bill. As contrasted with less than 10 percent in the case of all other medical services and supplies, about 40 percent of all expenditures for hospital and nursing home care are from public funds. Furthermore, about two-thirds of all consumer expenditures for hospital care are covered by private insurance, while such insurance meets less than

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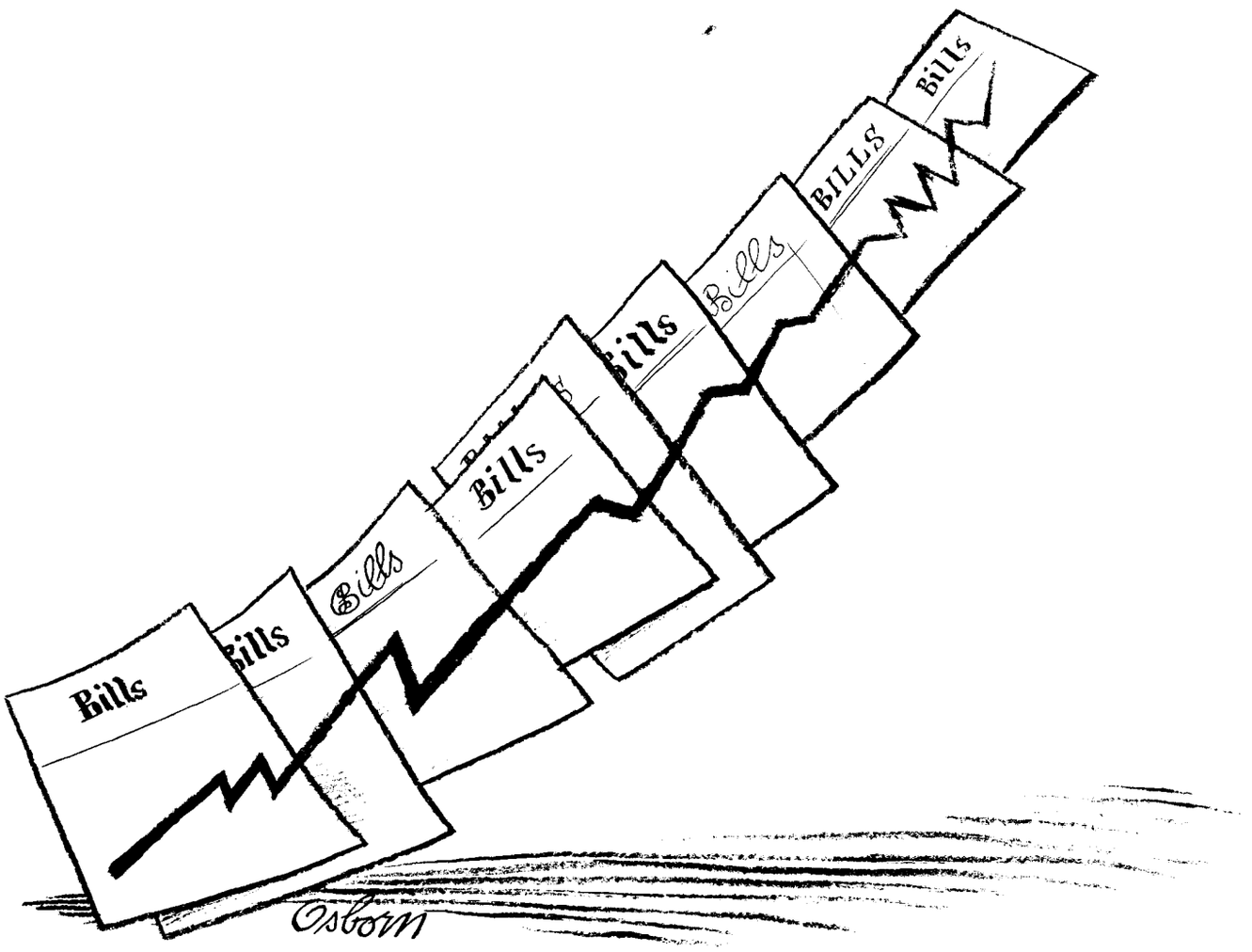

15 percent of the rest of the consumer's medical bills.

The needs of veterans, military personnel and their dependents, seamen and Indians now account for a large share of public, and particularly federal, expenditures for hospital care. Since the latter part of the last century, state and local funds have carried a large part of the cost of care in tuberculosis and mental institutions. Most large municipalities maintain general hospitals that care for indigent or low-income groups either without charge or at less than cost; increasingly, the costs of such care are being met through public assistance programs rather than by direct subsidy. (Public assistance also pays for a substantial amount of care in nongovernmental hospitals. Total vendor payments for medical care now account for one-fifth of all public assistance expenditures.)

The more extensive coverage of hospital than of other medical bills by private insurance has a historical background: the hospitals themselves, as a device for survival, organized the first general prepayment plans during the depression of the '30's. Out of them grew the present Blue Cross plans, now covering some 58 million persons.

The insurance companies entered the hospital insurance field somewhat later, but in recent years have expanded their coverage until today perhaps 85 million persons are covered by hospital insurance written by commercial carriers. Including participants in independent health plans such as HIP in New York and the Kaiser Foundation plans on the West Coast, and with an allowance made for individuals with more than one type of policy or coverage, some 140 million persons, or about three-fourths of the population, are now covered by some type of hospital insurance, according to the Health Insurance Council.

Insurance against surgical and in-hospital medical costs has also increased and now covers almost as large a proportion of the population as does hospital insurance. Prepayment of the cost of doctor's care in home and office and of dental service, eye care, drugs, etc., has developed at a considerably slower pace. Possibly 30 percent of the population are covered for physician's services in the office and home, about 20 percent for prescribed drugs, less than one percent for dental care. Coverage for these latter services has developed primarily under "major medical" insurance and group pre-

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payment plans.

About three-fourths of all health insurance is now provided through employee benefits plans. Employer contributions on a group basis are estimated to cover about 70 percent of the premium cost of the health insurance so provided.

Although three-fourths of the population have some type of health insurance, the scope of the protection varies from nominal to comprehensive. In 1961, private insurance met only 28 percent of the private medical bill (and 24 percent of the total cost of personal health care), excluding the cost of purchasing insurance.

The costs of medical care and the methods of paying them differ markedly among different age groups in the population. They tend to be low in childhood, to peak somewhat for women of child-bearing age, and to increase sharply in later years. Expenditures (public and private) for personal health care in 1961 averaged $128 per person under 65 and $315 per person 65 and over. Hospital and skilled nursing home care accounted for 34 percent of the total cost for those under 65. It was 52 percent for those 65 and over.

The methods by which these medical bills were paid also differed. Of the total of $5.4 billion expended for medical care of persons 65 and over in 1961, 28 percent came from public funds. For those under 65, public funds provided 19 percent. There is no good basis for estimating what part of the total medical bill of aged persons is met by private insurance. About 55 percent of those 65 and over, as compared with 76 percent under 65 have some type of health insurance policy. In general, policies available to aged persons have more limited benefits (as well as higher premium costs) than those open to younger persons.

Only a few studies have tied together all sources of paying for the medical care received by a given individual or family. One such study of hospital and medical expenses of Michigan residents in 1958 found aged families with less than $3,000 income averaging out-of-pocket expenses of $242, or about 14 percent of their average income of $1,700. These families incurred a sizable amount of expense in addition, paid for by a welfare or other agency and raising the gross medical expenses to nearly 20 percent of family income. By contrast the Michigan families headed by a person under 65 averaged medical costs representing only five percent of current income for the medical bills and health insurance premiums they paid themselves, or six percent if costs paid by others are included.

In addition to the costs of personal health care, the total direct health bill of the nation also includes certain nonpersonal items amounting in fiscal 1963 to a little over $4 billion. Among them are $1.4 billion for construction of medical facilities and half a billion for the regulatory and other activities of public health and food and drug agencies. The fastest growing items in recent years have been the cost of medical research, now $1.2 billion exclusive of the research investment of the drug industry and the expenses involved in prepayment of medical costs – the difference, that is to say, between premiums taken in and benefits paid out by insurance companies and non-profit plans; this now runs over $1 billion.

IDA C. MERRIAM

It's Not the Doctor's Dilemma, It's the Insurance Plan's

The extent to which voluntary health insurance, these last years, has been one of the nation's chief growth industries, shows up in the fact that as of 1963, over 800 private insurance companies are in on it. So are some 150 Blue Cross and Blue Shield plans, and perhaps 300 independent health care organizations, like HIP in New York or Group Health, Inc. in Washington. But instead of sitting pretty, all of them are running scared.

What benefits should they offer? (Purchasers recoil from rising premium costs, yet want broader benefits and more complete coverage.)

How should they rate their risks? (Averaging risks on a community basis makes coverage practicable for larger segments of the community, but good risks can be insured for less.)

Whom should they enroll? (Now that the better risks and those easier to reach are already insured, enlargement means including high cost prospects; but if enough people are left out, the government may step in.)

DUNCAN M. MACINTYRE, *professor of industrial and labor relations at The New York State School of Industrial and Labor Relations at Cornell, discusses these dilemmas of the private insurers.*

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Like opium, voluntary health insurance can be habit forming; a taste creates demand for more. Most of the 140 million Americans with health insurance like it, but many also say: "If my insurance covers hospital care, why not surgical care, too? And expenses for doctors' calls? And prescription drugs?" Yet an ever-widening range of benefits would mean higher premium costs. This is half of the benefit dilemma.

At the same time, a growing number of people, viewing their premiums as installment payments on medical expenses not yet incurred, say: "Since my health insurance coverage has been paid for, why shouldn't the insurer meet all the expenses which I incur?" If her bill for a 10-day hospital stay is $400, Aunt Sally announces (and the wish here is father to firm conviction) that her insurance policy or Blue Cross certificate ought to pay $400 – rather than $300 (10 days' care at $20 per day plus $100 for extra expenses). This is the other half of the benefit dilemma.

Interest in more comprehensive benefits, covering more kinds of expenses, goes hand-in-hand with interest in higher benefits paying a bigger percentage of the bills; both entail higher costs and higher premiums. But buyer-consumers of health insurance are like any other buyer-consumers – they want more benefits, but they are by no means eager to pay for them. Meanwhile forces largely outside their control, by increasing medical costs, intensify their discontent.

Most Blue Cross and Blue Shield plans and nearly all the independent plans (the Kaiser Plans on the West Coast, for example) provide primarily service benefits – guaranteeing payment for agreed levels of medical services or number of days of hospital care – rather than dollars. But as the costs of medical and hospital care, particularly the latter, have climbed, so have premiums, notably the premiums for service benefits, since these are especially sensitive to price increases.

Many fortunate consumers have transferred some or all their premium costs to their employers, but again, as costs go up and up, many employers are beginning to balk at "sharing" open-ended health insurance liabilities and are attempting to shift part of the cost back to their employees, through fixed dollar benefits, bigger deductibles and more co-insurance.

Dissatisfaction about increasing costs and premiums, a growing employer reluctance to write blank health insurance checks, inability or unwillingness on the part of some subscribers to pay high premiums are the ultimate components of the benefit dilemma. What should voluntary health insurance do now?

In figuring their premiums, Blue Cross, Blue Shield and the independent plans have usually relied on flat, averaged rates of incidence of the need for medical care, often called "community rates." Not so the insurance companies: Their rates have been based on the theory of insurance equity, reflecting both the expectancy of loss of the insured individual or group and that risk's fair share of the insurer's expenses. The competition between the plans and the insurance companies has in part been a rate or price competition, and has created the rate dilemma.

When the Blue Cross movement got under way in the 1930's, the infant plans covered hazards about whose insurability most insurance companies were, at best, skeptical. Created and controlled by "charitable" agencies – the hospitals – the plans paid little attention to risk selection or considerations of equity. Yet their success was remarkable.

The pioneer plans usually offered a single contract, providing, say, up to 30 days of hospital care per year. By enrolling subscribers through employers, they got the economies of group enrollment while avoiding over-enrollment on the part of the sick and under-enrollment on the part of the healthy. They used simple, flat rates – $5-$10 annually for a single subscriber, $10-$20 for a couple, and $18-$35 for families. A few used "dual-rates," with one rate for individual subscribers and another, higher rate for families. Rate increases were plan-wide and unrelated to the losses of particular groups.

Traditionally, Blue Cross and Blue Shield plans permitted group-enrolled subscribers who quit, retired or otherwise left their enrollment groups, to buy "group conversion" coverage. But the self-employed or those not in any enrollment group were left out. Consciousness of their enrollment obligations as community ventures, however, caused most of the plans by the end of World War II to sell "direct-pay" or "original non-group" contracts, usually at slightly higher rates or with reduced benefits.

In the early 1950's the Blue plans began to run into trouble. Price and wage inflation played a part, but as direct-pay and group conversion enrollment increased, non-group benefits began to eat up an increasing percentage of total income. Where initially they had insured a "select-risk" population, by 1950 the plans and their insurance competitors had enrolled half of the entire population, with the insured becoming average, rather than "select." Enrollment gains were slowing; future gains would have to include ever-increasing numbers of poor risks who would foreseeably use more benefits.

The community plans were also in a corner. Enrolling more bad risks meant higher benefit costs and higher community-average rates; not to enroll bad risks was to deny community obligations. Many of the plans began increasingly to rely on indemnity benefits, to offer a variety of contracts and to tighten underwriting rules. They increased the "equity" and reduced the "averaging" in their rates. Most of these changes were in re-

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sponse to competition. The insurance companies never abandoned equity rates; 60 years of experience had shown them that averaged rates were poor competitive tools, and their enrollment gains during the 1940's and 1950's proved this view correct.

By 1950, too, corporations and unions, the "wholesale" buyers of health insurance, were exerting enormous influence on the market. The corporation-wide benefit plan and the multi-employer, area-wide welfare fund were becoming common. It was difficult for, say, 40 regional and local Blue Cross and Blue Shield plans, each offering different contracts and different benefits at different rates, to combine to sell uniform Blue Cross-Blue Shield benefits to one national employer. It was simple for the insurance companies. More insurance companies were entering the group health insurance market, and to get profitable new business, the newcomers often had to lure established groups away from competitors. Many relied on rates to do this. As price competition sharpened, much of it aimed at the "jumbo" risk and groups blessed with low loss ratios, more and more competitive pressure was directed at low-benefit-cost Blue Cross and Blue Shield business, pushing them to turn to individual risk or experience rating.

Most community plans are apprehensive about these recent developments: if they rely solely on community rates, they risk losing some of their most profitable groups to competitors and face difficulty in maintaining low rates for senior citizens and others with modest or substandard incomes. If competition, particularly price competition, drives them into equity and experience rating, the end of bargain rates for senior citizens will, many believe, hasten the advent of public health insurance for older people and, ultimately, for the general population as well. This is the rate dilemma.

The enrollment dilemma is closely related to it. Most of the prime risks and employment groups are already enrolled. To expand horizontally, to sell or enroll 85 or 90 percent of the population, will be expensive both in sales costs and in benefit costs. Nevertheless, most voluntary health insurers stoutly maintain that they can accomplish the seemingly impossible and are assiduously courting senior citizen enrollment. Why?

If they don't enroll the unenrolled, especially the eight or nine million over-65's who now have no health insurance protection, the likelihood is that Uncle Sam will do the job for them. Some insurers are more enthusiastic about this prospect than others. Some plans are aware that they might serve as chosen instruments to administer the proposed federal medical care insurance programs. The insurance companies take a different position. Given time, they argue, enrollment of the elderly is perfectly possible under a voluntary system, although subventions from other policyholders, from agents in the form of lower commissions, and from the states in the form of tax reductions may be needed. Nevertheless, few insurers are unmindful of the fact that senior citizens' business is a money-loser, and that without it, better business could be done with the under-65 population.

DUNCAN M. MACINTYRE

Health as a Fringe Benefit

If group hospitalization was a child of the depression, health as an industrial fringe benefit was a child of the war, when government warnings against inflationary wage increases stimulated invention of new forms of incentive and remuneration. For some years, no large collective bargaining agreement has been complete without a health plan.

The union bargaining that has produced some 30 percent of the money spent on such plans comes in three stages: first, bargaining inside the union to set objectives and to resolve internal differences; then, bargaining with the company to get a plan into the contract or improve its benefits; and, finally, a new kind of bargaining with hospitals, doctors and insurers, jointly undertaken by company and union executives.

JEROME POLLACK, *previously a health plan negotiator with the United Automobile Workers and now professor of administrative medicine at Columbia University, reviews the structuring of union plans and foresees changes in them.*

In the past 15 years, a wave of "fringe" health benefits originated in collective bargaining and spread throughout the economy. As a result, most members of the labor force have come to draw a part of their pay in health benefits for themselves and their families – and an immense private venture into the social financing of health care, unique among nations, has come into being in the United States.

America emerged from the war aware that it could not return to the unprotected economy that had collapsed in the prewar decade. The war had stretched the economy but had suspended action on social benefits. Health insurance was especially long overdue and in one form or another – private or public – could not be put off much longer. Having organized basic industry, the unions were pressing for greater income and turning toward workers' security. They found wage increases first frozen and then frowned upon as inflationary, but

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a channel to benefits had been left open. Although most in labor would have preferred governmental health insurance, faced with a political climate that eschewed governmental action and an economic climate that accepted benefits as non-inflationary, the unions attempted to negotiate for insurance and pensions.

The first breakthrough came in 1946, after a strike in the bituminous mines and government seizure of the mines, when the Secretary of the Interior negotiated an agreement with the United Mine Workers establishing a welfare and retirement fund. The precedent was not embraced by other industries. However, early in 1948 a series of decisions by the National Labor Relations Board and the courts held that employee benefits are "wages" and "conditions of employment" and that employers are obligated to bargain over them. General Motors was restrained from unilaterally modifying its existing insurance plan, and following a strike in basic steel a pattern was eventually set by a Presidential fact-finding board which recommended a wage settlement of 10 cents per hour for pensions and "social insurance." Once the necessity to bargain was established and a financial pattern set, management and labor in many industries settled down to bargain in earnest.

Unlike wages, benefits redistribute income – from young to old, well to sick, breadwinner to dependent and employed to unemployed. Some workers originally objected that the union should not play God or government with their wages. Later, as benefits became accepted, younger members might prefer to bargain for maternity benefits while the older ones would want extended hospitalization. Members in high cost areas might want more to be spent on benefits than those whose medical costs are lower. To the credit of most unions, intramural contention over benefit advantages has generally been friendly and fraternal. Members were often remarkably ready to aid others in the expectation that they would be cared for when their turn came. They accepted the redistribution of part of their wages in this mildest of social revolutions.

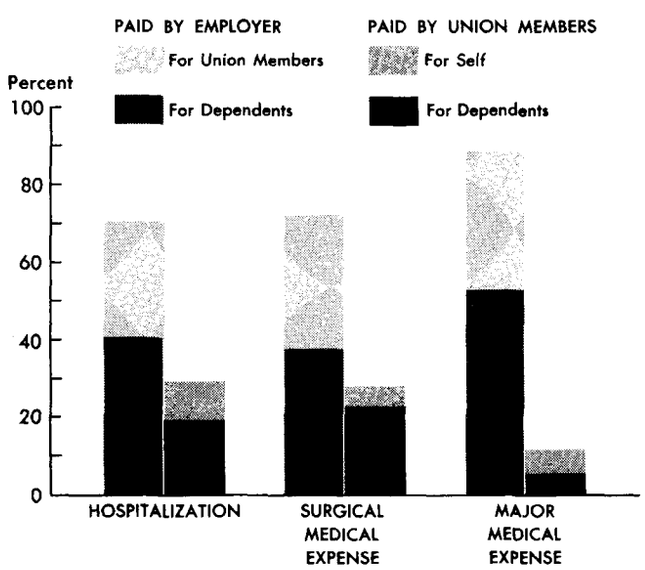
When the union serves its demands on the employer, bargaining descends from dreams to reality. However much labor's demands may be compromised or decimated in bargaining, the union chooses the content of the program. In most major benefit agreements, the union's paternity and philosophy is revealed. Whether it operates a health center to meet the special medical needs of workers or as a medical monument – an anachronism that some of the finer older unions find it hard to avoid; whether it builds and runs hospitals – as the Mineworkers have; whether it accepts what is available – as have most unions; whether it seeks the best available conventional plans while acting as entrepreneur of group-practice prepayment in hopes of something better – the two-front campaign of the Autoworkers; whether it seeks some custodianship over the quality of care – again pioneered by the Mineworkers but recently adopted by the Teamsters in New York – depends in the first place on the union. The company's maternal influence is also present. Its consent is eventually required. Some companies have brought their preexisting industrial health plans into bargaining; indeed "major medical" insurance grew out of management personnel's own health insurance needs and was pressed on the blue collar workers.

Employers have not, of course, capitulated without any resistance to these demands for "more" benefits. However, once over the big hurdle of beginning to bargain, many employers have accepted health care as a worthy way for employees to spend their wages. For their part, employees often preferred benefits over cash increases and were ready to divert wage increases and to pay out of pocket to build the benefits. For some years, therefore, the bargaining was easy; only recently has it stiffened perceptibly as the realization has grown that, unlike all other benefits, in negotiating over health care labor and management have caught a tiger by the fringe.

Hardly anyone had even remotely anticipated the rapidity with which the cost of health care and its insurance would shoot up. The extent to which insurance itself would contribute to increased cost by stimulating the utilization of services and supporting higher charges was not foreseen. In many labor contracts, health benefits are the most open-ended item of cost, and no one seems to know what to do about it.

Dollar limits on benefits (to which employers have often resorted) deprive patients of needed protection; yet failing to set such limits often means extending a

Who Pays for Collectively Bargained Health Plans?



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blank check to hospitals and physicians. Many employers have promoted proposals to insure only the larger expenditures for health care under plans that would withdraw some existing protection through deductible and coinsurance payments by the patients; but instead of withdrawing protection, these have generally been added to existing protection and have contributed to rather than curtailed expenditures.

For relief against increasing premiums, employees have pressed for full employer payment; this does not arrest cost increases which the employer continues to regard as a cost of labor. Companies have entered into such arrangements with misgivings, believing in principle that employees should share directly in the premium cost. Contrary to their early readiness to contribute, the companies' disposition to challenge and resist cost is growing; it could have a serious impact on a medical economy grown dependent on the support of labor and management.

Once they have agreed on how much to spend, labor and management find themselves on the same side in a new set of negotiations with the purveyors and insurers of health services. They confront an independent medical profession and such highly organized and prestigious institutions as hospitals – themselves one of the largest industries. They face specialized prepayment plans and the insurance industry now in the ascendancy in health coverage. As amateurs in health plans, labor and management are generally no match for these professionals. Moreover, the hospitals, physicians, prepayment plans and insurance companies themselves advance such divergent interests, aims and opinions that the consumer confronting them hardly knows what or whom to believe, or how to protect his own interest.

Some urge that health plans should cover only those expenses that families cannot budget for; others want to finance everyday care, including preventive and diagnostic services. Some hold as cardinal that the cost be spread broadly over the community; others insist that each group pay its own way. Some demand that prepayment not interfere in any way with medical practice; a few insist that it police cost and quality. The businessman who finds himself assigned to keep an eye on the company's health plan and the union representative who also has a few other responsibilities are unable to mediate, much less resolve, such disputes. They tend to affiliate with one or another camp or doctrine, rather than to appraise or act independently as consumers.

The first great wave of bargaining has spent its force, leaving great inequality in its wake. A national survey by the Department of Labor in 1959 showed that while some employers contributed more than 13 cents per hour toward health, accident and life insurance plans for production workers, others – as many as one-eighth of all establishments – paid nothing. Some industries averaged 7.3 cents; others as little as 2.4 cents. In apparel and other finished textile products, nearly 45 percent of the employers did not contribute. Where the employer is less able to pay, the employees may also be less able to make up for the deficiency and thus go with lesser protection. To go from an auto plant with fully-paid broad benefits to a nearby textile plant with low wages and little protection is to encounter the "Other America" in health care.

Left to their own devices, the forces that have produced these disparities will no doubt deepen the inequality. A leveling upward at this time is unlikely without regulation in such areas as a minimum-wage allocation toward benefits, some minimum-benefit standards and some requirements for insurers to strengthen the risk-sharing in health insurance.

The unions that supplied the main motive force for benefit acquisition and expansion are now themselves harassed and challenged by receding membership and influence. Preoccupied with other matters, they are not likely to mount as vigorous an effort toward health plans as they did in the past decade and a half. The best that the unions have been able thus far to achieve is probably typified by the United Mine Workers Fund. Its rehabilitation of disabled miners has been inspiring – though yet to be emulated by the conventional plans. It has successfully monitored the quality and cost of care for its beneficiaries. Its chain of 10 hospitals and medical centers, built in a region of inadequate facilities, was of acknowledged excellence. Yet there may be something prophetic in the fact that this pioneering fund is now facing a decrease in beneficiaries and diminished income and has found it necessary to sell the hospitals and curtail its operations. The employment from which the miners sought security is now itself somewhat less secure. The rampant technology that has reduced the labor force in the mines is also moving in the same direction in other industries.

The advantages of employer financing of economic security have already been demonstrated; now a more sobering appraisal of the limitations of such financing is being revealed by labor and others looking for legislation to provide health insurance for the aged through social security. This is not necessarily seen as an assault on voluntary health insurance but as a means of dealing with people who are generally outside the wage and benefit economy. It is not difficult to foresee a similar campaign for some subsidy to finance health insurance for the unemployed. New forces are coming to the fore that are likely to change the direction and shape of health protection in the future; there is bound to be a reconsideration of the role of public and private financing, whereby both can be employed to better purpose than either alone.

JEROME POLLACK

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Socialism in the Armed Forces

If you're an Army child who grows up to follow your father's profession, socialized medicine will carry you from the delivery room to the grave. If you enlist or are drafted, and stay in, you will receive government-operated health care throughout your military career. If you're a veteran with a service-connected disability, or indeed in some cases without one, you're entitled to tax-supported hospitalization even if you got out as soon as the war was over. If you're a dependent of a serviceman on active duty, or an Indian, or a federal prisoner, or a member of Congress, you too are eligible for public health care.

Those who warn Americans against the lures of socialized medicine usually ignore the fact that about 30 million of them – nearly one in six of the whole population – are already living with it.

In the Capitol itself, for the past third of a century, the Navy has staffed and operated a clinic where members of Congress, their staffs, and visitors to the building receive first-aid and preliminary diagnosis for a total of 40,000 patient visits a year. Senators and Representatives in need of hospitalization usually go to the Naval Hospital at Bethesda, or occasionally to Walter Reed, where they are listed as "supernumeraries" and pay $36 a day. Famous heart-attacks cared for at these institutions included a former President's and the current Vice President's. Yet the speeches of many of these officials decry government care as impersonal or inefficient, and their votes express fervent opposition to its extension.

Both politicians and the AMA, however, evince a marked disinclination to castigate socialized medicine in the major forms in which it is currently practiced in the US. The symbol of the sacred relationship between doctor and patient packs a powerful magic, one that is usually strong enough to prevail, but the symbol of the undying debt of the country to the returned veteran, especially him of the purple heart, is still stronger.

Those who have presumed to criticize service-connected medicine cite two main reasons. One concerns quality – many an ex-serviceman has memories of rounds with medics at times when he had no choice of physician that lead him to cheer attacks on uniformed ineptitude; in the past, charges of politics in the Veterans Administration have struck responsive chords, though the grounds for them in respect to quality of care were sharply narrowed following President Truman's appointment of Dr. Paul (Ring-the-Night-Bell) *Magnusen as the VA's medical director.*

The more enduring charge leveled against the VA is that easy entitlement leads to overuse of care. Yet here the symbols get active again: a VA hospital has special non-medical amenities. Doing something for the boys is a persistent preoccupation of Service Clubs and Women's Auxiliaries – where else can a hospital patient say, "Take me out to the ball game" and have tickets laid on?

RICHARD DUDMAN *of* The St. Louis Post-Dispatch *has tallied the number of American citizens now served by government medicine, and checked some criticisms of its operation.*

The first American venture into socialized medicine took place in 1798, when the Public Health Service was created to care for American merchant seamen in government-built marine hospitals. US merchant seamen now number 117,000, and it still takes care of them. It likewise provides complete health care for 43,700 active and retired Coast Guard personnel and for several hundred commissioned officers of the Public Health Service and officers and crewmen of the Coast and Geodetic Survey. In addition, some 340,000 Indians, scattered through 23 states, and 43,000 Eskimos, Indians and Aleuts living in isolated villages in Alaska depend largely on the Health Service's hospitals, health centers and field clinics; the care of some federal prisoners is handled by the Department of Justice.

In the Armed Services, the 2.7 million soldiers, sailors and airmen on active duty are fully provided for by public funds. The most prominent of their number, General of the Armies Dwight D. Eisenhower, has enjoyed full government health care throughout his adult life. Their dependents – averaging about 3.8 million wives and children, plus 55,200 dependents of uniformed members of the Coast Guard, Public Health Service, and Coast and Geodetic Survey are likewise cared for. The word Medicare, now used to designate the proposed financing of hospital care for the aged through social security, originated in military jargon after the Defense Department inaugurated its Dependents Medical Care Program in 1956.

But government medicine's biggest group of eligibles by far is the country's war veterans, of whom 22,176,000 are now living. A veteran is automatically entitled to admission to a Veterans Administration hospital if suffering from a service-connected disability. If his disability is not service-connected, he is still eligible if the hospital has the necessary space and if he asserts that he is unable to pay for hospital and medical care.

Total cost of federal government medicine in the medical-health budgets of the various agencies is just over $5 billion a year. HEW's $2.5 billion budget in that

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field is by far the largest, being swelled by major items that benefit individual patients only indirectly. It administers grants for hospital construction under the Hill-Burton Act and those for research and training under the National Institutes of Health and other agencies. Runners-up are the Veterans Administration, which spends $1.1 billion, and the Department of Defense, which spends $.9 billion, mostly for direct personal care.

That medical care of good quality is obtainable at service hospitals and veterans' installations, particularly in view of the close relationships between veterans' hospitals and nearby medical schools, is at least tacitly admitted by the political users of such facilities, though the project of making comparable provisions for the general population was rejected in these words by President Eisenhower when campaigning in 1952: "They [the Democrats] want socialized medicine; we want voluntary medicine, because we want the very best kind of medical care that can be brought to every man, woman and child in the United States, and we know that that can't be done by a bureaucrat sitting behind a desk several thousand miles away from the person who needs the medical care."

In another of his more definitive utterances on the subject, he said: "Any move toward socialized medicine is sure to have one result; instead of the patient getting more and better medical care for less, he will get less and poorer medical care for more."

But today, most criticism of government medicine is directed not at the quality of the care but at the ethics it induces.

Especially in the case of the veterans' hospitals, patients are blamed for considerable chiseling. As one disgruntled physician put it, after practicing in a VA hospital, "You get a lot drunker on free whiskey than you do when you have to pay for it." Many private physicians, while praising the medical and surgical standards of the institutions, complain that patients go oftener and stay longer than they would if they were paying the bills, stretch the test of service-connected disabilities, and, where there is no service connection, lie about their resources.

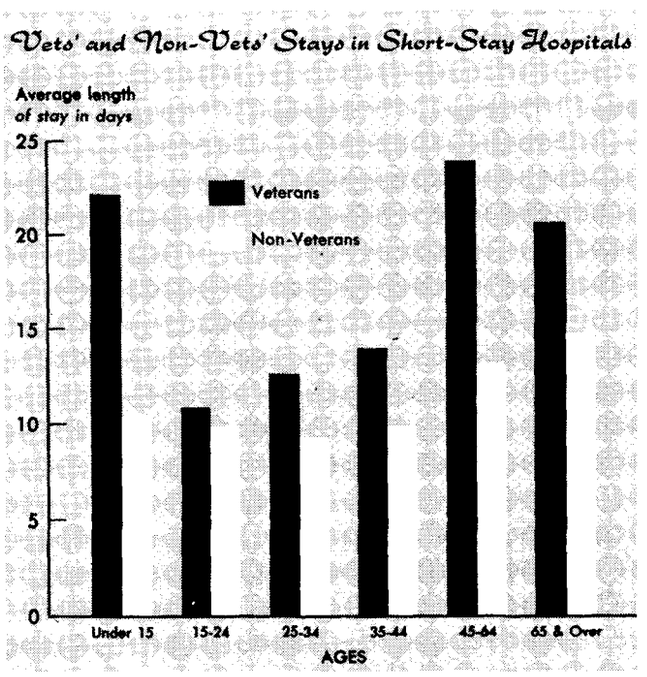
The House Committee on Veterans' Affairs hears many such complaints and has a standing offer to investigate where specific details are given. But when the committee recently checked out 27 patients who allegedly could well afford to pay, it found that most were living on nothing but their Army pensions of less than $100 a month and three had never been in hospital. When the committee does turn up an abuse, either by running down a complaint or in the course of one of its spot checks of VA hospitals, it refers the case to the Justice Department. A letter to the patient is often enough to elicit payment.

Statistics on the length of patient-stay can be used to prove almost anything. Critics of government medicine cite figures showing substantially longer stays in government than in private hospitals. The averages are affected, however, by the fact that many government patients have no families to care for them after discharge and thus spend more recuperative time in the hospital. Private as well as public hospitals find that extraneous events affect stays: the superintendent of one such has noted the effect of the hunting season, when men patients stay a shorter time and women patients stay longer, presumably because there often is no husband at home to look after them in their first days out of hospital.

Accusations of chiseling are likewise lodged against doctors. The tabulation covering the first five years of the Army-operated Medicare program showed that of the 3,860,000 servicemen's dependents who had received in-hospital care under the program, 1.3 million were treated in civilian hospitals by civilian physicians. The fees the Army paid them totaled $354 million.

The average annual cost to the government of this civilian medical and hospital care runs about $70 million a year, divided almost equally between the doctors and the hospitals. The patient must pay the first $25 of a hospital bill, or $1.25 a day, whichever is greater, as well as part of any necessary private duty nursing charges. On the average, the patient pays 9.3 percent of the total bill.

The Army's Office for Dependents' Medical Care reports that fees paid to doctors are intended to be payment in full but that this fact "occasionally escapes the attention of an individual beneficiary and an indi-



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vidual physician." It says such M.D.'s often drop their extra charges when confronted with "correspondence focusing the physician's attention on this concept."

The General Accounting Office, when it conducted its own evaluation of the Medicare program two years ago, also made some interesting observations on the fees charged by physicians. In each state, a schedule of maximum fees has been negotiated by the Office for Dependents' Medical Care with the state medical society. A physician is expected to charge his normal fee, but he cannot charge more than the negotiated maximum without filling out a special form and applying for a waiver.

The medical societies of most states have distributed the maximum fee schedules to their members despite government requests that they be kept confidential. (The Office for Dependents' Medical Care, after asking them not to, refused to pay printing and mailing costs, but the medical societies sent out the lists anyhow.)

What the GAO did was to compare the physician's fees actually charged with the maximums on the lists. In states where the lists were distributed and the physician knew for sure how much they could charge, their fees almost invariably were exactly the maximums. In the few states where the lists were not distributed, the fees varied widely and averaged about 25 percent below the maximums.

The GAO estimated that the government pays out $3 million to $4 million a year in surplus charges in states where the lists were distributed and the physicians charge the maximums instead of their normal fees and proposed that the Medicare agency renegotiate its fee schedules in states where physicians mostly charge the limit. The Army rejected the proposal, expressing satisfaction with its policing system which consists in reliance on the state medical societies to stop any overcharging by their members. Two years later, the situation, including any abuses, appears to be approximately unchanged.

The moral, applicable to any future expansion of government medical service, appears to recommend inclusion in any national health plan of an effective watchdog system, watching doctors as well as patients.

RICHARD DUDMAN

The Time Has Not Come

In 1916, the American Medical Association's Committee on Social Insurance warned its House of Delegates that "the time has come, when we can no longer resist the social moment." The next year, the governing body declared that "in the end, the social forces that demand these laws will indignantly force a recalcitrant profession to accept that which is unjust to it and that which is to its detriment."

But Morris Fishbein, appointed editor of the AMA's Journal *in 1924, was firm in his belief that the time could be postponed, and for a quarter of a century did much to postpone it. And when the AMA at long last removed the Fishbein from its throat, it was to clear its voice for an even louder cry of defiance, paid for by a war chest of some $2 million raised through membership assessments and conducted by a public relations firm whose gift for nostalgia introduced nationwide display of Sir Luke Fildes' painting, "The Doctor," with the warning: "Keep politics out of this picture."*

According to the AMA, whose figures differ from those of government sources, the country has some 280,000 M.D.'s, counting both those in practice and those who have retired. The great majority belong to, and support the policies of the AMA; it has some 161,000 dues-payers (dues are $45 a year) and some 39,000 special status members. True, there have been doctors' groups that have not gone along with the AMA, most recently the Committee of 27 that supported President Kennedy's 1962 bill for financing hospitalization for the aged through social security. But in general the medical profession has resisted government entry into fields other than those, like the Kerr-Mills Act, that are tied to a means test, or related to construction of facilities.

The recent history of major bills in Congress proposing extension of medical care from public sources, from material compiled by Congressional Quarterly, *is detailed below. The AMA has opposed all but Senator Taft's 1946 proposal and its successors and the Kerr-Mills Act of 1960.*

1935: The report of the President's Committee on Economic Security endorsed the principle of compulsory health insurance as part of the social security system.

1943: The Wagner-Murray-Dingell Bill called for creation of a national health-insurance plan, financed through a payroll tax.

1944: The "economic bill of rights" included in President Roosevelt's State of the Union Message specified the right to "adequate medical care," and the 8th An-

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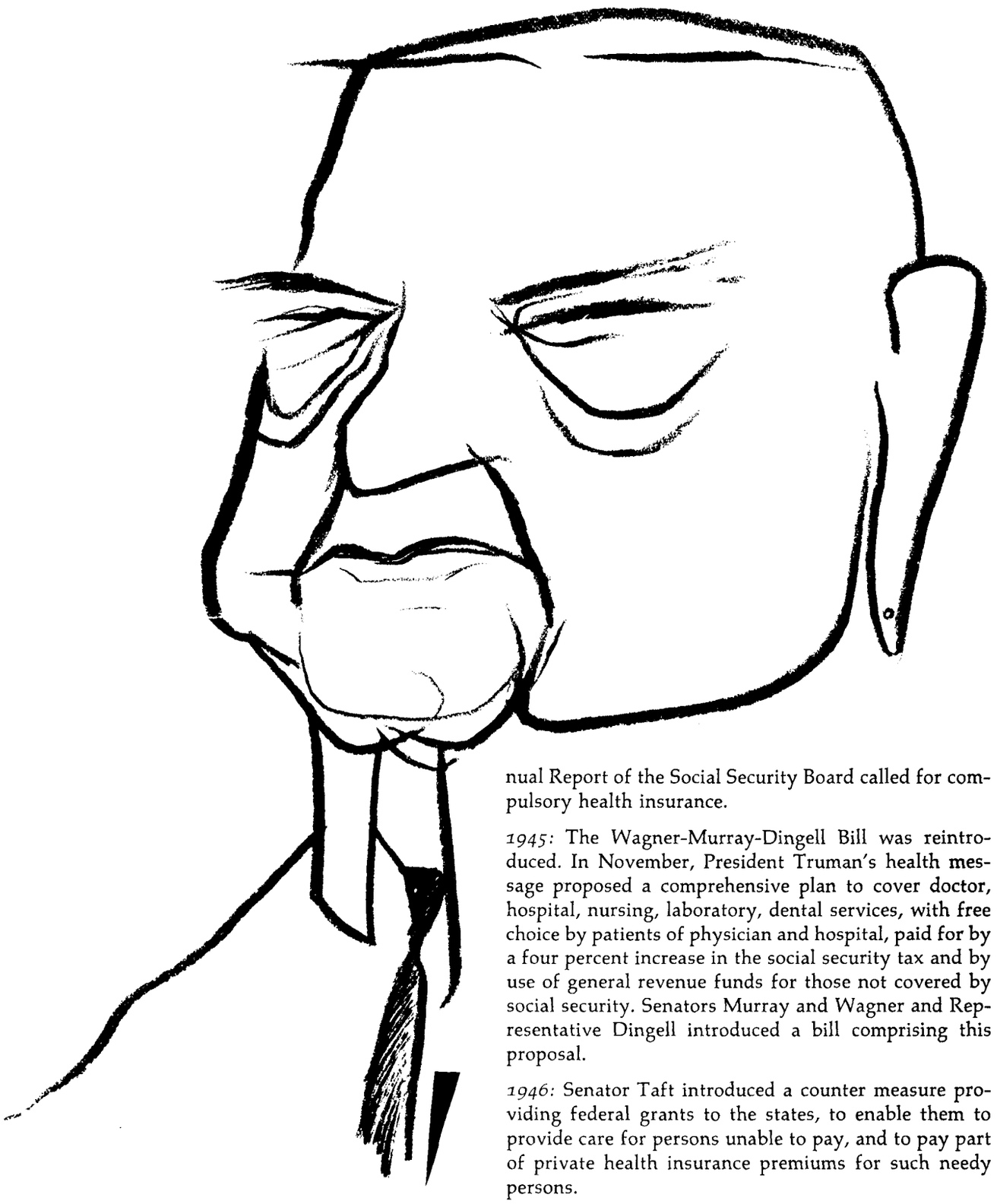

Osborn

nual Report of the Social Security Board called for compulsory health insurance.

1945: The Wagner-Murray-Dingell Bill was reintroduced. In November, President Truman's health message proposed a comprehensive plan to cover doctor, hospital, nursing, laboratory, dental services, with free choice by patients of physician and hospital, paid for by a four percent increase in the social security tax and by use of general revenue funds for those not covered by social security. Senators Murray and Wagner and Representative Dingell introduced a bill comprising this proposal.

1946: Senator Taft introduced a counter measure providing federal grants to the states, to enable them to provide care for persons unable to pay, and to pay part of private health insurance premiums for such needy persons.

1947-48: Hearings on both the Truman proposal and the Taft bill led to no action.

1949: President Truman's State of the Union Message and subsequent health message called for passage of his plan, without result.

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1950: The 1950 amendments to the Social Security Act provided federal funds to share in the costs of "vendor payments" made by the states to doctors, nurses and health-care institutions on behalf of persons on public assistance rolls.

1952: The Murray-Dingell-Celler Bill proposed hospitalization coverage of retired persons entitled to social security and their dependents.

1954: President Eisenhower advocated government reinsurance to protect private health insurance companies against unusually heavy losses, with the program financed from premiums paid by the companies. The measure reached the House floor but was defeated.

1956-57: The Administration requested legislation permitting small insurance companies and voluntary health insurance organizations to pool their resources in expanding their hospital and medical expense coverage.

1957: Representative Forand introduced a bill proposing up to 120 days of combined hospital and nursing care and necessary surgery for OASI beneficiaries. Hearings on this measure were held in 1959 by the House Ways and Means Committee; in March, 1960, in connection with the Social Security Act amendments, it came to a Committee vote and was defeated.

1960: In May, the Eisenhower Administration proposed a "Medicare" measure, offering either matching grants to states to pay for various medical costs of aged persons with incomes of $2,500 a year ($3,800 for a couple) or less, or funds to enable such individuals to buy private commercial insurance.

The Ways and Means Committee included a cut-down version of the Eisenhower proposal in the Social Security Bill passed just before Congress recessed for the 1960 conventions. Upon return to Washington, both candidates for the Presidency proposed action: Senator Kennedy, on his previously introduced version of the Forand Bill; Vice President Nixon, on a version of President Eisenhower's May proposal as introduced by Senator Javits. Both were defeated.

Instead, the amendments adopted contained the Kerr-Mills Bill; they offered grants to encourage the states to spend more for elderly indigents under public assistance and to introduce the new Medical Assistance to the Aged (MAA) program. The latter allowed participating states to be reimbursed for medical costs for elderly persons not poor enough to qualify for public assistance but judged unable to meet their medical bills.

1961: Senator Anderson and Representative King sponsored a new version of the Forand, Anderson, Kennedy measures; hearings did not lead to action.

1962: Senator Anderson, with co-sponsorship by Senator Javits and four other Republicans, offered the Administration's proposal as a Senate floor amendment to the Public Welfare Amendments passed by the House. The proposal was defeated by a 52-48 vote.

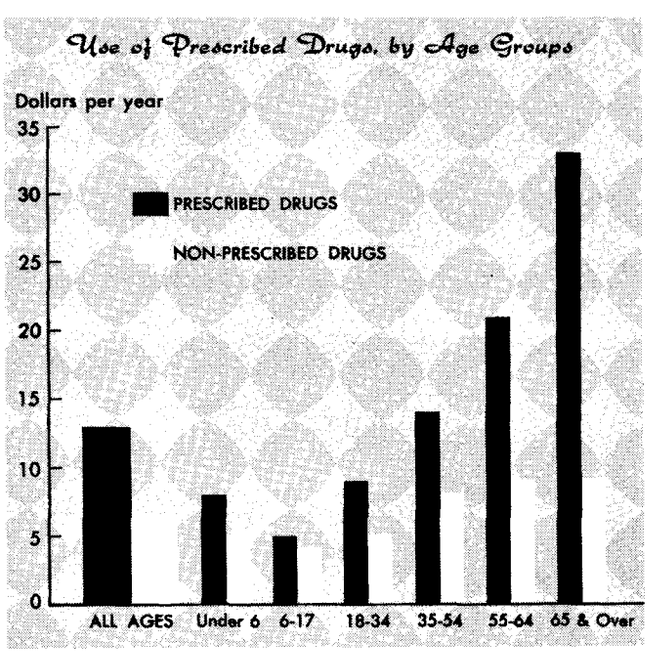
In both 1961 and 1962, federal participation in state medical programs for persons on public assistance was increased.

What Next for Medicare?

In September of 1963, Rep. Wilbur D. Mills, Chairman of the House Ways and Means Committee, announced that he did not plan to ask for legislative consideration of Medicare this year. Cynics have commented that 1964 would be a better time anyway, since extensions of the Social Security Act have traditionally been saved for their electoral value in campaign years. Large blocs of over-65 voters are located in critical big states – California, Pennsylvania and New York all have more than a million citizens over 65.

But there is more to the 1963 delay than a normal postponement, more even than can be credited to the activities of lobbies such as those of the AMA and its political offshoot the American Medical Political Action Committee, the insurance companies and their numerous allies.

Not only the chairman of the House Ways and Means Committee is opposed to financing health care through social security. In spite of the addition in 1963 to Ways and Means of two favorably inclined Democrats (replacing known "antis") the division is so close that the absence of one of the proponents, due to illness severe enough to jeopardize his return to Washington



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this year, would probably keep the bill from the floor even if a vote were taken.

But if the Legislative Branch is approaching Medicare with more deliberation than speed, the Administration has not done much either. The one-to-a-session strategy that concentrated White House energy on passage of the trade act in 1962 was repeated in 1963 with respect to the tax bill; both the tax bill and Medicare fall within the jurisdiction of Ways and Means.

On February 2, 1963, the President, whose stand in favor of the type of legislation now proposed is clear from his record as a Senator, sent up a message urging passage of various programs for the aged, Medicare among them. But asking and demanding are quite different things; real White House pressure was saved for tax reduction.

Even within Health, Education and Welfare – the Cabinet department responsible for forwarding the bill – official optimism has been muted. Assistant Secretary Wilbur Cohen, in early background meetings with newsmen, gave no indication that he anticipated early Congressional action.

In June, when President Kennedy addressed the second annual convention of the National Council of Senior Citizens, he attempted to raise the visibility of the measure, but at that time newspaper space was too absorbed by civil rights stories to give his attempt more than superficial coverage.

Over the years, support from the general public has lost some of its buoyancy: health care bills are becoming a hardy perennial almost able to challenge the hoary seniority of agricultural adjustment measures. The present version includes modifications worked out in 1962 in the Javits-Anderson compromise, but the changes were not substantive. Medicare's most active proponent all along has been organized labor: the AFL-CIO has issued a new set of supporting pamphlets. But repeat performances tend to become perfunctory.

As proposed, the Hospital Insurance Act of 1963 would have provided funds to cover hospital costs of the elderly by an increase of one-fourth of one percent in the social security tax paid by both employers and employees, and four-tenths of one percent by the self-employed, on an income base raised from the present $4,800 to $5,200. Covered individuals (and coverage from general tax revenues would be extended to the 2 1/4 million aged ineligible for social security) would be offered three options, among which they must choose before reaching 65:

► up to 90 days of inpatient hospital costs, with the patient paying $10 a day for the first 10 days, or at least $20.

► up to 180 days, with the patient paying all of the first 2 1/2 days' average costs.

► all costs for 45 days.

These benefits would be available for each period of hospitalization.

In addition, beneficiaries would be entitled to 180 days of care in a skilled nursing home after leaving the hospital, and 240 home health care visits by community nurses and physical therapists in any year, and to care after the first $20 worth for hospital outpatient diagnostic services.

Resistance to this measure relies for the most part on two arguments. One points to the growth of insurance coverage over the past decade, and insists that private and non-profit hospital insurance can be further extended to approach enrollment of most of the elderly population. The difficulties attendant on such enrollment are discussed on pages 19 through 21.

Some critics of Medicare argue that the Kerr-Mills Act of 1960, offering medical aid to the aged through federal grants to states adopting plans under the act, eliminates the need for further health legislation. But only 28 states, the District of Columbia and two territories have adopted Kerr-Mills plans. Help has reached less than one person in a hundred over 65, far fewer than would be indicated by figures on the incidence of illness among the elderly. Through September, 1962, more than a fifth of the 346,847 applications approved up to that time were transferees from other state programs. Reluctance among the elderly to apply for such aid, in addition to repugnance at being declared medically indigent, has been increased by provision in some state plans for reimbursement from the estates of persons aided.

A third argument against the proposed Hospital Act castigates it as an entering wedge for an across-the-board public health insurance plan, or even for a national public health service. In itself, the act would have no effect whatever on the institutional structure of American health care. What it would provide is a means of paying for the use of hospital facilities: choice of physician and of hospital, and all other aspects of treatment, would remain unaltered.

Money for Medical Research

The manner of raising medical research funds, private and public alike, testifies to the fact that in every American family, suffering by a close relative – beloved or expensive or both – has been directly witnessed. Consequently, while appeals for money for medical research in general might fall flat, or meet the resistance accorded the highbrow and the vague, appeals for re-

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search to mitigate suffering such as was undergone by mother, husband or child produce results.

The advantages of such money-raising methods are dubious. Diseases do not fall into compartments; separate organizations to research specific illnesses can encourage conceptual rigidities as well as administrative duplication. Not counting the millions of man (or more often woman) hours given as volunteers, the 60 to 70 national voluntary agencies that solicit funds in small amounts from the public – through Christmas and Easter seals and the like – spend enough on the process to reduce quite substantially the funds actually available to forward their purposes. The table below shows the distribution of funds raised by the major voluntary agencies in their fiscal years ending 1950-60.

The establishment by Congress of the National Institutes of Health displayed the same predilection for specifying the diseases to be researched. Seven separate institutes bear names everyone knows: allergy, arthritis, cancer, mental health, heart, dental research, neurological diseases and blindness. Appropriations to them are what is known as "line items" – the money is designated for a particular institute, not to the NIH as a whole. Only this year was new sophistication introduced with the raising of NIH's Division of General Medical Sciences to institute status, and the formation of an Institute of Child Health and Human Development – the latter non-categorical, but easily understood.

Nevertheless, since World War II, massive medical research has yielded massive results. In February, 1947, expenditures on medical research totaled $88 million, with industry putting up 40 percent of the total, philanthropy and endowment 28 percent, and government 32 percent. In February, 1963, the total reached $1.5 billion with 63 cents of the dollar federal government money. NIH distributes most of the funds, but medical research figures in the budgets of 10 government agencies – Defense, AEC, Veterans Administration, National Science Foundation, etc.

How does the NIH come by all this money? The field of health has strikingly illustrated the Congressional axiom, never underestimate the power of a chairman. The postwar failure to get a national health plan through Congress has in very considerable part been due to the stultifying skill of Representative Wilbur D. Mills as Chairman of the House Ways and Means Committee, and Senator Harry Flood Byrd as Chairman of the Senate Finance Committee. Similarly, the postwar success in obtaining substantial and increasing grants for medical research and training is largely due to the enthusiasm of Representative John E. Fogarty and Senator Lister Hill.

When Congress forces on the Defense Department more money than has been requested, it's news. Fewer headlines have been devoted to its consistent practice of upping Administration requests in the medical research area, yet in every fiscal year since 1953, NIH appropriations have exceeded Administration requests – in one year by 45 percent, and in several years by 36-39 percent. In 1961, the federal funds allotted NIH passed the half-billion mark; two years later, they are forecast at close to a full billion. (In 1963, however, the Administration itself asked for a substantial increase, for use in the new mental health program.)

Name of Agency	Funds Raised	Percentage Allocation of Funds Raised					
		Medical treatment	*Research Grants*	*Lay and MD Education*	*Community Services*	*Fund Raising*	*Other Purposes*
American Cancer Society.	$35,082,580[1]	—	32	29	20	11	8
National Foundation	33,487,480	42	16	12	7	17	6
National Tuberculosis Association	26,740,906	2	4	37	31	17	9
American Heart Assn....	26,663,224	—	37	24	14	12	12
National Society for Crippled Children and Adults	17,444,885	59[2]	2	9	3	14	13
United Cerebral Palsy ...	10,270,000	34	7	10	28	13	8
National Association for Mental Health	5,789,573	—	7	36	28[3]	10	19
Muscular Dystrophy Association of America..	5,568,237	23	39	11	7	13	7
Arthritis and Rheumatism Foundation	4,108,675	41	24	20	4	8	3

[1] Includes $5,372,115 in legacies and bequests and $1,353,839 of interest and other income.
[2] Includes sizable expenditures classifiable also as "community services."
[3] Includes expenditures for medical aid.

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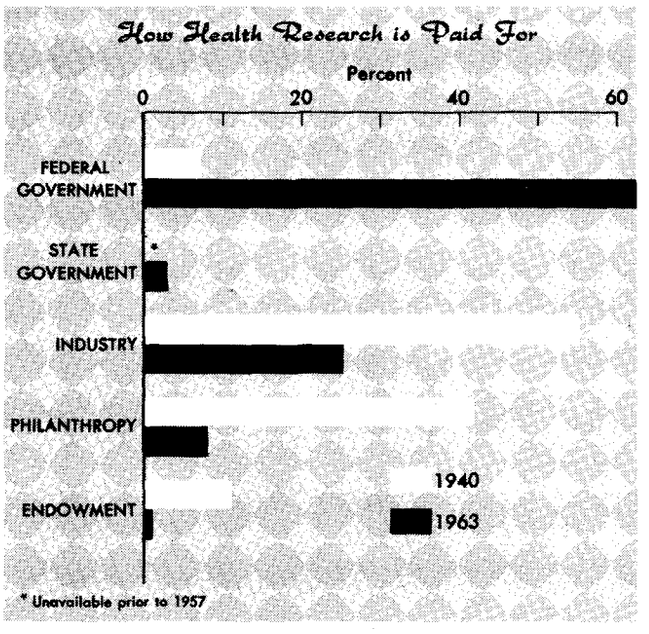

With so large a segment of all medical research funds coming from government, new importance attaches to the mechanism for deciding who gets how much for what. NIH's grant-giving technique permits a very wide measure of *laissez-faire;* initiative in selecting what is to be investigated rests largely with the researchers who put in applications for support.

Applications go to NIH's Division of Research Grants, which designates them for the appropriate Institute and sends them to be assessed by one or another of 45-50 study sections, composed of outside scientists representing various disciplines – biochemistry, physiology, etc.

The study groups designate projects as acceptable or unacceptable, and sort the acceptable ones according to four levels of priority rating. But usually, enough money has been available to support almost all projects rated acceptable.

Recently, the Intergovernmental Relations Subcommittee of the House Committee on Government Operations has been asking questions as to how much buck-passing goes on under this system: do the Institute's advisory councils rubber-stamp the recommendations of the study groups, and the Surgeon General those of the councils, with the Institutes themselves unstaffed for critical project analysis?

By and large, the medical scientists who are at the top of their professions, though many of them have federal grants, do not need to seek money – more often, their time is competitively sought after by universities, medical schools and private foundations. But each has his own stable of likely colts, many of whom have been trained on NIH grants, and practically all of whom are potential candidates for research support. (Large and growing segments of NIH funds are used to train such manpower: NIH supports more predoctoral students than any other government agency, including the Office of Education with its grants under the National Defense Education Act, and gives more direct support to post-doctoral advanced students as well.)

Beginning under President Eisenhower, the Surgeon General requested the councils to reserve for a second look the lowest 10 percent of the projects rated acceptable, but even then, relatively few have been rejected.

A jacking up, to introduce criteria of excellence as over against acceptability in the judgment of projects, is now going on inside NIH, and it is possible that Congress may stiffen its appropriation procedure. The basic legislation establishing the Public Health Service differs from that of most agencies by placing no ceiling on authorizations. At the 1963 hearings on PHS organization, a change to provide a ceiling was proposed.

The AMA, the FDA and Quacks

Anthony J. Celebrezze has joined together the forces of the federal government with those of the American Medical Association in a holy war against medical quacks. This was accomplished at the Second National Conference on Medical Quackery conducted during October, 1963, in the vulgar pomp of the Sheraton-Park Hotel's Cotillion Room in Washington, D. C., in an atmosphere reminiscent of the naming of Miss Rheingold. Slender brunettes wandered about with klieg lights to aid photographers who might wish to take pictures of contraband merchandise including various sorts of sex rejuvenation equipment, electronic machines sold for diagnosis and cure of differing diseases, displays showing why calories *do* count, enlarged photographs of a once ugly woman, now horribly maimed because she participated in a beauty restoration which turned out to be carbolic acid. There were speeches, one by a man who felt TV had helped put down quackery because it had forbidden advertisers to demonstrate remedies for piles, an exhibition sure to distress the family; another by a woman who felt *education* was the answer (indeed, several speakers felt the one real hope lay with an educated and therefore outraged youth) and she was suggesting that every college student should receive training in spotting quacks at work.

You left this two-day convention with the feeling you had been at a training camp for finks who on their re-

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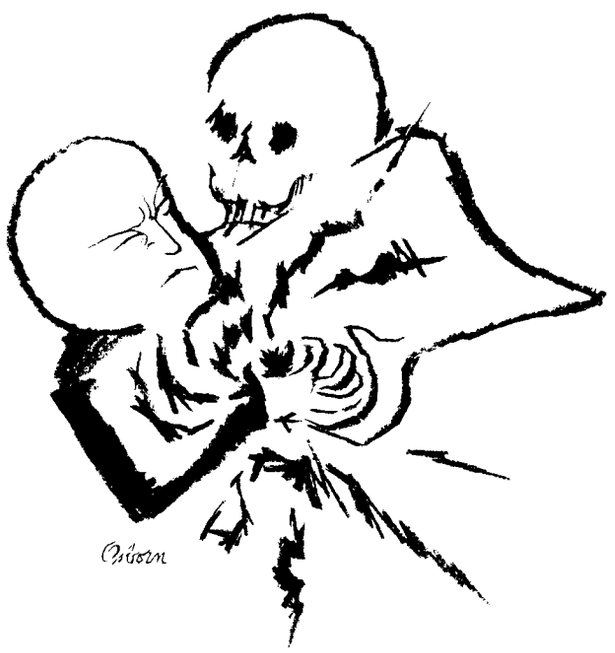
turn home could make a collect telephone call any time to the Food and Drug Administration to rat on any doctor not a member of the American Medical Association, the one credential agreed by all to be as authentic as an FBI badge.

Dr. Edward R. Annis, president of the American Medical Association, said at the onset that the American people were giving $1 billion to the false purveyors of mystic healing. Not only had they lost their money to the siren songs of modern charlatans, others had lost their lives. Physicians had a grave responsibility for battling this evil, and indeed, the AMA had been at it since 1847. Unfortunately in a few instances physicians actually had been aiding and abetting medical quackery by the use of worthless, secret remedies. A classic example was Krebiozen, found to be ineffective in the treatment of cancer by the Department of Health, Education and Welfare. Twelve years ago the AMA reported this alleged drug was worthless. But in the intervening years, the promoters of Krebiozen managed to distribute and sell it. In desperate or hopeless cases of cancer where medical science could not offer an effective treatment, the patient or his family has forced the physician into administering something called Krebiozen. The physician simply did not have the heart to refuse a desperate person's request. However, the physician must remember the consequences of this act. In the case of Krebiozen, he unwittingly gave support to one of the greatest frauds of the 20th Century.

Since Krebiozen stands so obviously as the principal example of quackery to both government and AMA, it is worth going into its history briefly. The controversy began in 1951 when Dr. Andrew C. Ivy announced the preliminary results of a study of 22 advanced cancer patients who had been treated with Krebiozen. In 20 of these there had been beneficial results, he said, and claimed only that "the substance merits a thorough clinical study." Ivy certainly would not then have been considered a quack. He was vice president of the University of Illinois, a distinguished professor of physiology, a former executive director of the National Advisory Cancer Council of the Public Health Service, and representative of allied governments on the subject of medical ethics at Nuremburg. Ivy had been working with Krebiozen since 1949 when he had first met Stevan Durovic, a Yugoslav who had been conducting research on it in Argentina. The theory of Krebiozen was that the body itself contains an anticancer agent that explains the occasional spontaneous disappearance of the disease, and that this agent can be stimulated, extracted from tissues and used in treatment. Durovic got his extracts from the blood serum of horses.



Not long after Ivy announced the results of his study, the *Journal of the American Medical Association* in a report on Krebiozen reviewed the case histories of 100 patients treated with the substance and found that 98 of them failed to show real improvement. The AMA report disdainfully described Krebiozen as a "secret remedy." Its findings, however, were questioned because of the 100 cases, 24 were said to have been misrepresented because administering physicians reported different conclusions than those of the report. Fifty-eight other patients were said to have been so near death that they never received the fourth injection of Krebiozen, and none of the patients had been on the drug for long. In early November of 1951, Ivy was suspended from the Chicago Medical Society because of his involvement with the "secret remedy." In 1952, a University of Illinois study urged further trial of the substance in both animals and people. In 1961, after extensive experimental work, Ivy and Durovic presented results of treatment of 4,000 patients to the National Cancer Institute, hoping that these studies would provide enough information for the Institute to design clinical tests. But the Institute felt Ivy's results were inadequate, and the proposed tests were tabled until further scientific evidence could be provided. Cancer Institute officials, however, made statements in private that cast doubt on the validity of their objections.

In June of 1963, Durovic filed an application for continued distribution of Krebiozen as an experimental drug under the new drug laws. The FDA, however, made no secret of its determination to stop sale of the product, and before the application could be refused, Durovic withdrew it. This effectively banned the sale of Krebiozen from interstate commerce. In August of this year, 24 experts appointed by National Cancer Institute met secretly to review 504 of Ivy's best cases, that

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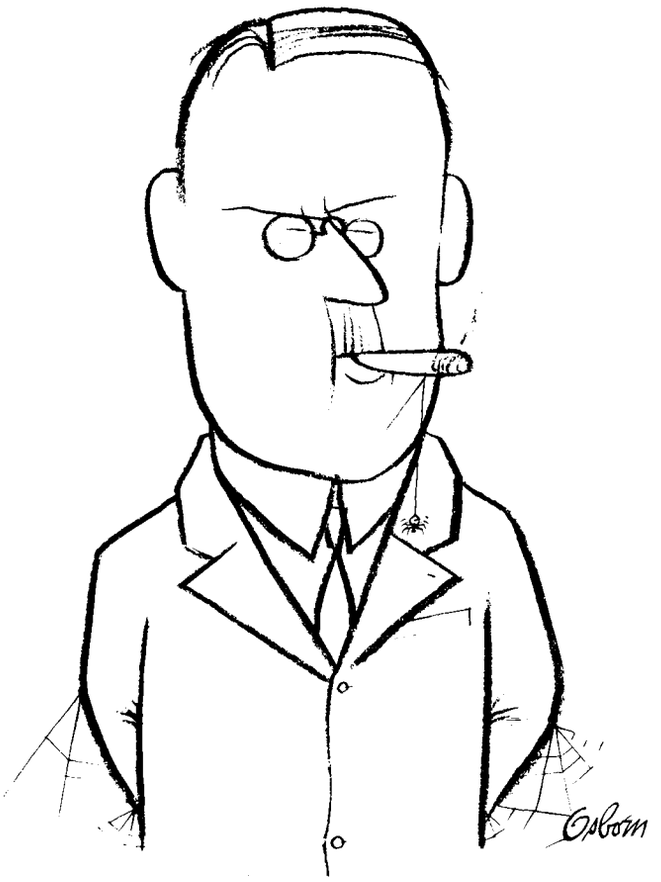
is the cases where Krebiozen was said to have had marked effect. The 24 specialists unanimously urged that a clinical test of the drug not be undertaken since they claimed Krebiozen was worthless. Because of the great secrecy in which this inquiry was conducted, Senator Douglas has felt it necessary to make his own independent examination of Ivy's cases.

So we learn that the greatest fraud of the 20th Century is a drug which the AMA opposed at its inception on the basis of questionable test results, and which the federal government never has tested scientifically.

James Ridgeway

The New Drug Story in Washington



By December 2, the Subcommittee on Antitrust and Monopoly of the Senate Judiciary Committee is expected to reach a decision on whether or not to demand production of data under subpoenas that have been outstanding since May. A favorable vote would set off a new investigation as explosive as the one instituted in 1960, when the late Senator Estes Kefauver was chairman. But in view of the committee's current membership such a vote would be something in the nature of a miracle. The roll is very different from what it was when the Democrats on it were Kefauver, O'Mahoney, Neely and Carroll, and the Republicans, Langer, Dirksen and Wiley; it now comprises Democratic Senators Hart (the new chairman), Dodd, Long of Missouri, McClellan, Ervin and Kennedy, and Republicans Dirksen, Hruska and Keating. The formation of a Conservative Democrat-Republican coalition against the chairman would thus be easy – indeed it requires some fancy mathematics to put together a vote in which Senator Hart can come out with a majority.

Senator Hart inherited what was in any case a delicate situation. The subpoenas Senator Kefauver had put out required submission of documents by various pharmaceutical companies; when committee members challenged his action, he found himself no longer possessed of the votes to validate it. That is why the subcommittee had not met for some time prior to his death.

The occasion for the subpoenas was a charge by Mr. Herman Nolen, president of the pharmaceutical firm of McKesson-Robbins, that rival companies were engaged in concerted practices designed to prevent his company from selling drugs under generic names at low prices in Colombia and Venezuela. (A generic name is the standard name by which a drug is designated in medical school teaching, as contrasted with the trade name that may be given to it by a drug firm.) McKesson-Robbins claims that its Colombian-Venezuelan sales nevertheless yield a profit, and that it is meeting a consistent refusal on the part of US drug firms to supply it with raw materials.

When Senator Hart, on September 11, outlined the problem to the subcommittee, he found members of three minds. Some strongly favored withdrawing the subpoenas as unjustified harassment of the drug industry. Some thought an investigation would be a legitimate exploration of possible action affecting the law as it applies to antitrust overseas marketing. Some were unsure. Their decision, reached unanimously at the end of the meeting, was to get more facts, but to let the subpoenas stand for the time being on the grounds that without them, possible evidence might vanish. Fact-finding then went forward in executive sessions.

The political problems involved were more than usually complicated. The Senate Foreign Relations Committee likewise has heard the president of McKesson-Robbins in executive session – it followed the hearing with a formal letter to Senator Eastland of the Judiciary Committee indicating that it did not intend to investigate, but thought the State and Justice Departments of the Executive Branch should. The Justice Department says a preliminary antitrust investigation is going on,

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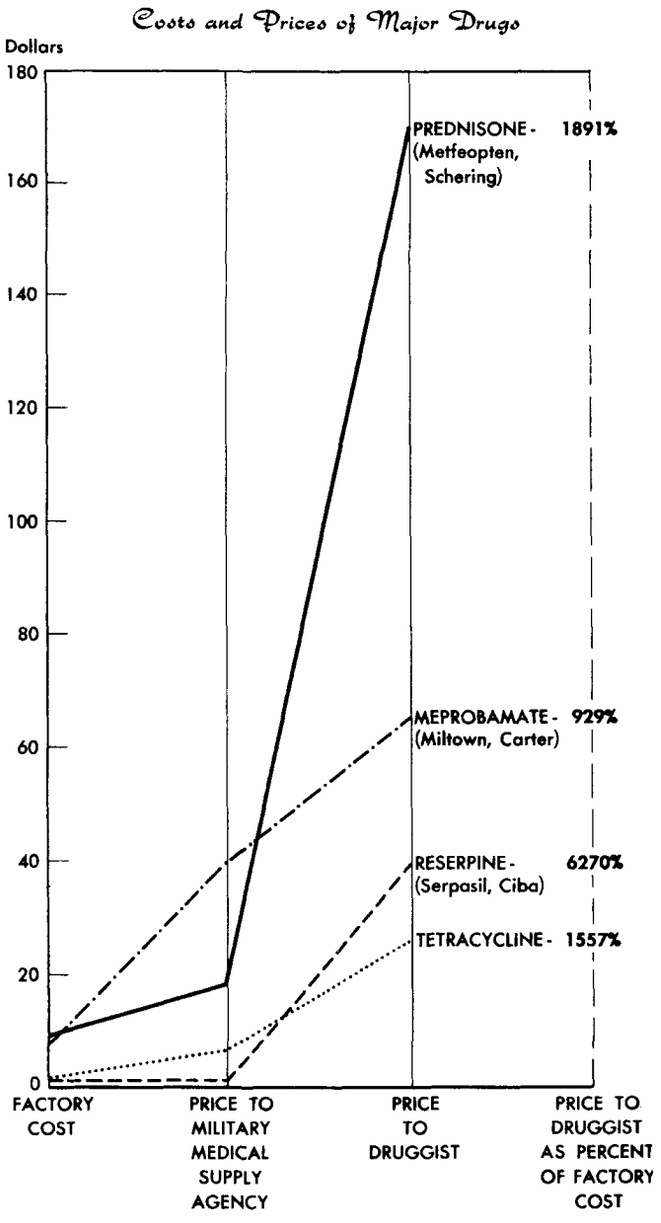

but has issued no subpoenas. The general attitude of the Administration toward Colombia as a participant in the Alliance for Progress is one of patience worn thin by prolonged lag in reform.

Meanwhile, a series of special articles in the *New York Herald Tribune*, on both the domestic and the Latin American aspects of McKesson-Robbins' enterprise, by a research reporting team headed by William Haddad (formerly an associate director of the Peace Corps) has brought the scandal to the public's notice. Some observers are suggesting that the drug industry in the affected countries will be nationalized overnight if the McKesson-Robbins' program fails; others, that an investigation will become the cause of nationalization. Still others declare that even if the price of pills dropped from 30 cents to one cent, the peasant in an underdeveloped country still couldn't pay for them, and that more good can be done by charitable donations by drug producers, unaccompanied by alterations in price.

Seen from the Caribbean, the availability of low-cost drugs, and particularly antibiotics, is a life-and-death matter, and a correspondingly hot domestic political issue affecting a government's tenure. If proof were needed, Castro's willingness to barter people for drugs shows the value put upon them in developing areas. Indeed, the Colombian government promptly made an informal inquiry as to the suitability of sending up a minister authorized to give evidence when the subcommittee announced hearings.

The sale of drugs under generic names is a current subject of litigation in this country as drug firms seek a court upset of a provision of the Kefauver-Harris Drug Bill of 1962 – a provision that resulted from hearings which Senator Hart chaired. Under this act, the Food and Drug Administration is required to see to it that every time a trade name of a drug appears on a container or in advertising, the generic name of the drug is also carried, in type at least half as large. The effect of this requirement, in the case of non-patented drugs (and about 50 percent of all prescriptions are composed of such drugs), would be to build in some competition by giving pharmacists a choice in filling prescriptions. Previously, a pharmacist has had no choice; the doctor writes down a trade name, and he must supply what is called for, pay what the manufacturer charges for it, and in turn charge his customer a retail mark-up of an administered wholesale price.

Drug companies emphasize their need to recover not only their overhead and marketing costs but the very substantial sums that they risk annually on the uncertain productiveness of research – a point of view similar to the rationalization for oil depletion allowances to petroleum companies that must be continually engaged in the costly uncertainties of prospecting for oil. In 1962, the pharmaceutical companies spent $238 million on research intended to benefit human patients (they provide medicines for animals too); their 1963 budget was $257 million.

This is a cogent argument, but it is sometimes overworked. The Kefauver hearings showed instances where the research and development of a drug was done by a foreign firm, with no more effort by its American licensee than the filing of papers. Yet the price in the US was higher, and in some cases two, four and five times higher than in the country of the drug's origin.

Two other sets of figures previously produced by the Antitrust and Monopoly Subcommittee are likewise worth recalling.

The chart above shows the factory cost per thousand of producing 5-milligram prednisone tablets (for arthritis), 400-milligram meprobamate tablets (a tran-

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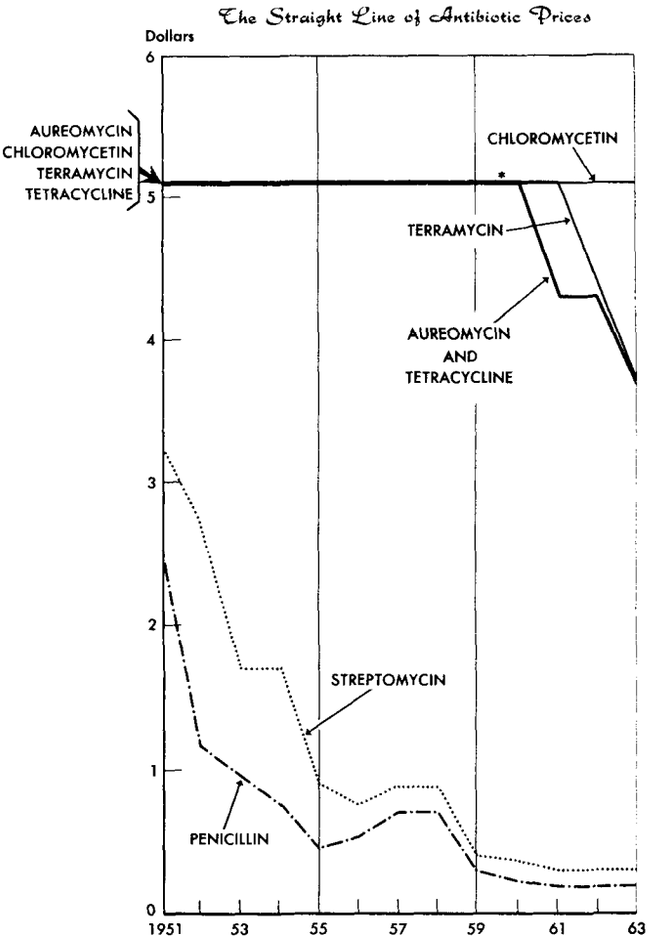
quilizer), .25-milligram reserpine tablets (for hypertension), and the cost per hundred of 250-milligram capsules of the antibiotic tetracycline. It likewise shows the prices at which makers of these drugs sold them to the federal agency that buys drugs for the armed forces on a competitive contract basis, the prices simultaneously charged druggists, and the relation between what the druggists paid and the factory cost.

The chart on this page shows the straight line of prices of four patented antibiotics, maintained without variation for close to a decade prior to the Kefauver hearings. These prices held level at the same time that the bulk prices of two other antibiotics which happened to be widely produced and marketed competitively fell sharply. The price – $5.10 – charged to druggists over this period was for sixteen 250-milligram capsules of the four drugs (tetracycline was not introduced until 1953). It also shows the fraying of the straight line that occurred after the start of the hearings. The bulk prices shown are for 10 grams of streptomycin, 10 million units of penicillin.

As we go to press, Senator Hart's ability to muster a majority of his subcommittee in favor of undertaking a new investigation hangs in the balance. But further evidence of the apparent existence of an international cartel in drugs has been placed in his hands as a result of the *New York Herald Tribune's* research and editorial interest. As in the early days of World War II, trust-busting may be about to take an international turn.

HELEN HILL MILLER

The Straight Line of Antibiotic Prices



* Hearings started by Senate Sub-Committee on Anti-Trust and Monopoly (Kefauver Committee)

Time the US Caught Up

"I do not know any problem or remedy more obvious which now faces the Congress of the United States. The average older couple has about $50 a week to live on. The average older person living alone has about $20 a week. There is no room . . . for a serious illness. . . .

"The person who has no resources – he gets a kind of treatment. He indicates that he is needy and he gets some sort of help. But there is another person who I think is one that concerns us a good deal, and that is the person who may have $3,000 or $4,000 saved up, or who may own their own house with a mortgage, and may have two children who may be in their 40's. If that person gets sick, the husband or the wife, they are in the hospital for more than two weeks, maybe two or three months, and there isn't anyone in this room who has not had a member of his family in the hospital at one stage or another of his life for a long time, and who does not know how much it can cost. So it may run up to $1,000 or $2,000 or even higher. . . .

"Now, the program we suggested will provide that he will set aside during his working years an average of $13 a year, not a burden for anyone employed, $13 a year. And that man and woman will know when they are over 65 that they will never be a burden upon their children and never be a charity case upon the national government because they will have earned their way, and that is what we want. . . .

"There isn't a country in Western Europe that didn't do what we are doing 50 years ago or 40 years ago, not a single country that is not way ahead of this rich, productive, progressive country of ours. We are not suggesting something radical and new or violent. We are not suggesting that the government come between the doctor and his patient. We are suggesting what every other major, developed, intelligent country did for its people a generation ago. I think it is time the United States caught up." – PRESIDENT JOHN F. KENNEDY *to the National Council of Senior Citizens, Inc., June 13, 1963.*

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Considerations for Policy-Makers

The first national health insurance plans adopted in Europe met resistance from organized medicine very similar to that of the AMA in this country now, with doctors declaring that state support would lower the quality of medical care. Yet over the decades, conflicts between "the plans" and the doctors have been mostly about pay, not treatment. The quality of treatment is good: European mortality rates compare favorably with American, and European populations have a coverage that is not available to millions in the US. Yet the percentage of the national product that is spent on health in European countries is not greater than it is here; in fact in all of them it is slightly less.

In concluding its survey, *The New Republic* presents two articles indicating some considerations that future US policy-makers might well take into account. One reviews recent developments in the countries that have national health programs. The other is by an American doctor who opposes adoption of an over-all health plan here, now, but for a reason diametrically opposite to that of the AMA: he thinks current medical institutions are changing rather rapidly for the better, and wants experimentation to continue without being encased in the rigidities of a comprehensive plan.

I. The European Experience

Eighty years ago, Bismarck introduced the world's first national health insurance program. In 1911, Lloyd-George initiated Britain's first statutory health insurance. By World War II, most European countries had health insurance laws of some sort on their books, about half of them limited to low-income wage earners. After the war, almost every medical program was expanded and improved: the British National Health Service, set up then under the Beveridge plan, celebrated its fifteenth anniversary this June. Consolidation of the European Common Market, especially if Britain joins, may set off still further developments.

The widely varying European programs exhibit three dominant patterns:

1. A health service, as in Britain. *This provides universal access to benefits without reference to an insurance or contribution principle and at virtually no cost to patients.*

2. Health insurance with indirect or reimbursement-type benefits. *Eligibility for benefits depends upon payments or contributions made by or on behalf of the beneficiary, with or without a government subsidy. The patient pays the doctor himself and is reimbursed for a specific portion of his outlay. This is the French and Swedish pattern.*

3. Health insurance with direct benefits. *The financing is the same as under 2, but benefits are administered more nearly as under 1. Doctors and hospitals are reimbursed by the health insurance fund directly. The patient pays nothing, within specified benefit limits, at the time he uses the services. This is the Italian pattern.*

The patterns are rarely found in completely "pure" form – even in Britain, the patient must pay a small fee for each prescription and certain other services. In France, hospitals are increasingly reimbursed directly. Norway's plan combines elements of all three patterns.

In some of these programs governmental agencies handle administration; in others, authority is delegated to one or more autonomous agencies operating under varying degrees of government surveillance.

ANNE RAMSAY SOMERS, *research associate at Haverford College, recently back from a first-hand study of Western Europe's health insurance and health plans, points up problems that are common not only to those plans but also to American group and public payment systems.*

In each of the major European countries, all or the great majority of the population has access to essential hospitalization, physicians' services, and preventive care at little or no cost to themselves at the time they use such care. The financial barrier has been largely removed.

This has been accomplished without exorbitant costs. While absolute figures have increased substantially, just as they have in this country, the percentage of national income spent on medical care in most European countries is, according to the International Labor Office, as low or lower than in the United States. A survey made during the early 1950's, for example, reported the following percentages: England and Wales – 4.1; Belgium – 4.1; Denmark – 3.7; Netherlands – 3.8; France

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– 4.4; Norway – 4.5; US – 4.5.

In the past few years, there have been no spectacular developments: the period has been one of consolidation, of concentration on administrative and financial problems rather than on expansion. Conflict between the health insurance institutions and the medical profession over the amount and methods of professional compensation has, in the minds of many health plan administrators and doctors, overshadowed all other issues.

Not infrequently, professional bitterness has erupted into full public view. Six years ago, the British Medical Association, angered by delay in getting a pay increase, announced plans for a phased "withdrawal" from the National Health Service by all GP's. Most observers interpreted this as a Harley Street "U-phemism" for a general strike.

In France, a prolonged battle between the doctors and FNOSS, the national organization of social security agencies responsible for negotiating fee-schedules with the medical societies, and the government, reduced the value of the protection available to insured patients under the reimbursement system of benefits from a theoretical 80 percent of doctors' bills to as little as 30-40 percent.

Last summer the entire Italian medical profession staged a brief strike for higher remuneration from the health insurance organizations. About the same time the doctors of Vienna struck over the form of their remuneration. Belgian doctors struck briefly in July of this year. Professional relations in Germany, while less publicized, are reported to have been equally embittered.

Only Scandinavia escaped this phase. The explanation does not seem to lie primarily in the organization of programs – they differ considerably among the three principal countries – Sweden, Norway, and Denmark; it is rather that, in the view of one Norwegian social security expert, Scandinavian doctors are well paid and know it. Also, doctors and patients alike accept the necessity of governmental action in many areas of modern life, including health.

What has been true of Scandinavia may soon be true of all Europe. Despite continuing professional unrest, I believe that relations between doctors and administrators are far better today than they were a few years ago. The change is perhaps most conspicuous in Britain where, last fall, the Porritt Committee released its report. The group was headed by the then president of the Royal College of Surgeons and sponsored not by the government but by British organized medicine. Although the report contained many specific criticisms of NHS, there was also the significant statement, "Basically, the concept of a comprehensive national health service is sound." On the capitation method of remuneration, once a focus of GP complaint, the Committee observed, "Although we think the capitation system is far from ideal we have received no evidence which persuades us that other methods of payment would prove any more successful."

Behind this change of attitude lie many developments, including the BMA's failure to achieve unity in its own ranks with respect either to the threatened "withdrawal" or any "alternative services." Most important, however, was the 1960 Report of the Royal Commission on Doctors' and Dentists' Remuneration (Pilkington Committee). Conciliatory to the doctors, the Commission proposed an average increase of about 22 percent over 1955-56 earnings, and recommended continuing review machinery to advise the government on periodic pay adjustments.

In France, both legal and institutional changes have resulted in a gradual improvement of protection and relaxation of tension. A 1960 law provided that in departments where the Conféderation des Syndicats Médicaux Français refused to sign collective fixed-fee agreements, the social security organization could sign such agreements with individual doctors. Since then, collective agreements have been signed in all but five or six departments, though not in the Seine (Paris) and Lyon, where about a quarter of the country's insured population is located and where a "rebel" professional organization representing primarily the most prosperous doctors has challenged Conféderation leadership. But according to a recent survey, 47 percent of the doctors of Paris have signed individual agreements, and 70-80 percent of the younger doctors and those practicing in the suburbs.

Also in 1960, a major change of leadership brought to the presidency of the Conféderation a man who is apparently seeking a workable solution with the government and FNOSS: in the 1963 pay negotiations, the Conféderation and FNOSS lined up together in favor of a substantial rise and obtained government approval of an increase averaging about 14 percent as against about 18 percent requested.

In Italy, Germany, and Austria, relations appear to have improved since last year. Significantly, in none of these countries does the debate involve the basic question of the state's right to establish a health service and set professional fees. On the contrary, most doctors in these countries, especially Austria, have long been enthusiastic supporters of compulsory health insurance as a means of increasing their incomes. The issue is primarily the current amount of remuneration or, at most, the method: some Italian doctors would like to have the French reimbursement system of benefits in place of their direct system, feeling that patients are less likely to abuse it.

In brief, the medical profession is accepting what appears to be inevitable, and finding that it is not so bad after all. In words of one British consultant, "I still

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have all the private patients I want and the government pays me £2,000 a year to take care of those whom I used to take care of for nothing."

Under these plans, the annual or biennial collective negotiations are becoming much like other major collective bargaining dialogues in modern society. The European doctor should – and probably will – come out very well financially, for his is one of the most difficult, expensive, and exacting professions and he enjoys a high degree of public support.

What effect have the European public programs had on the quality of medical care? A good deal of evidence indicates that they have contributed substantially to the improvement of European medicine. They have reduced previous qualitative disparities, and the leveling has primarily been a leveling-up. An official discussion of the recent French hospital and medical school reforms, published by the Ministère de la Santé Publique, starts with the proposition that, thanks to social security, hospitals are no longer refuges for the indigent, that the very concept of indigence has disappeared, and that, from now on, the hospital, *as the center of care for all social classes*, must be improved, both scientifically and in its amenities.

Complaints regarding quality of care and abuses by both doctors and patients are of course numerous. When the British Health Service was being debated, Aneurin Bevan, then Minister of Health, is reported to have said, "Every time a ward maid kicks over a bucket in a hospital ward, I shall be called to account. . . . We shall enfranchise complaints." Such "politicization" of the ward maid's bucket carries with it the danger of demagogic and political manipulation of the program but it also provides a forum for widespread discussion of needed reforms and improvements and opportunity for effective action.

Needed reforms are going forward in many European countries. The French have recently embarked on a far-reaching reorganization of their whole system of medical education and the relations between medical faculty and hospital staff. The new CHU's – Centres Hospitaliers et Universitaires – will be much more in line with the great university medical centers in the US except that there will be even greater emphasis on full-time teaching and hospital staff. In Britain, the Ministry of Health has initiated a ten-year $1.5 billion hospital planning and building program. Some 200 projects are on the planning boards; a few, like the beautiful new outpatient building for the Selly Oak Hospital, Birmingham, are already in operation.

Needless to say, not all the results of health insurance have been positive. Exaggerated use of drugs, especially where provided free or nearly free, appears to be an international phenomenon. Family doctors may be called more often than necessary. In some localities, the existence of insurance seems to have encouraged hospitalization where it is not absolutely necessary from a medical point of view. Hospital stays are typically long by US standards.

Future issues with potential significance for other countries appear to be:

1. How fast will medical care costs rise? Today, most comparable items – a day in the hospital, a visit to the doctor, a prescription – are considerably cheaper than in the US. But the worldwide phenomenon of rising medical costs, especially hospital costs, is present in Europe too and will affect the workability of present medical care institutions.

2. Will employers and employees be willing and able to continue to pay the bulk of the costs through payroll taxes, as is now done on the Continent, or will the state have to assume most of the costs directly, as it has in Britain?

3. If the state eventually pays most of the costs, what of the autonomous administrative organizations? Will they be superseded, as in Britain, by direct governmental administration?

4. Can the indirect or reimbursement system be made to work well enough to survive, as the Swedish experience suggests? Or does the French experience indicate that it is impossible to achieve adequate and stable benefits with this method and encourage the conversion to some form of direct benefits? If the latter, will health insurance end in some form of national health service?

Anne Ramsay Somers

II. New US Patterns

In the light of European experience, and of recent developments in the US, what kind of policy will make available to all Americans the health care consistent with the state of the medical arts and the resources of this country?

Robert S. Morison, *M.D., Director for Medical and Natural Sciences of the Rockefeller Foundation, compares American practice with that in various Western European countries and suggests where attention should be concentrated in an assessment of the cost and quality of American health care.*

The most dangerous feature of greater government participation in medical care now is the probability that it would serve to solidify patterns of practice that are becoming increasingly obsolete every day. Since most of the enemies of greater government participation in medical care are by and large the enemies of change in general, this argument is little used by those who op-

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pose the growth of a government role in medical care. But the general public should be more aware than it is that the establishment of a single nationwide scheme for meeting the costs of medical care is more than likely to retard the development of new and suitable forms of medical practice.

Take what has happened in England. As Mrs. Somers noted in her report, it is simply not true that the quality of medical care provided by the National Health Service is inferior to that available to the great majority of Englishmen before the scheme went into effect. All competent observers agree that it is better, especially perhaps in the far more equitable provision of specialists throughout the country. Nevertheless, it is not nearly so good as it could and should be. Its more glaring defects, however, are the result not of radical innovation but of a tendency to prolong and even intensify the defects of the past.

The heavy emphasis on general practice, the almost complete separation of the general practitioner from the hospital and the specialist, the tendency to prescribe some sort of drug at every visit whether the patient needs it or not, even the chronic shortage of hospital beds were all characteristic of British practice before the scheme. The operation of the scheme has only reinforced them.

This is not the place to argue the pros and cons of general practice, and I will not attempt to do so. I will simply assert that the rapid growth of medical knowledge is making it increasingly difficult for a single individual to offer anything more than a small fraction of what medicine as a whole has to offer the general public. This fact was reasonably well recognized by experts in medical care when the British scheme was being founded some 20 years ago. Nevertheless, it was felt desirable for several practical and political reasons to preserve the traditional merits of the general practitioner together with the sacred doctor-patient relationship and the free choice of a physician. In pursuit of these objectives and in order to preserve something of the old incentives, the GP in Britain is compensated according to the number of patients he attracts. Even though there is a ceiling (3,500) on the total number who can sign up, the ordinary doctor must usually confine himself to the following activities: (1) taking care as rapidly as possible of ordinary aches and pains; (2) certifying patients for disability compensation; (3) trying to identify the occasional case which is serious enough to justify referral to the hospital with its group of specialist consultants.

The British hospital is another world from the GP's office. It is staffed entirely by specialists with some of the highest qualifications to be found anywhere. Although there has been a deplorable lag in the provision of physical facilities, the level of professional services available is without much doubt more consistently high than in the US. At the risk of making a dangerous oversimplification, one might say that English medicine is more or less uniformly mediocre as practiced outside the hospital and uniformly very good at the hospital level. In the US, quality is much more variable both inside and outside the hospital, ranging from rather poor to excellent in both cases. Over-all, the advantages and disadvantages seem to cancel themselves out, so that such measures of effectiveness as infant mortality and life expectancy are strikingly similar in the two countries. What this country's lack of system allows which the British scheme makes rather difficult is continued experimentation with new forms of practice appropriate to the rapidly evolving nature of medical science.

Thus an increasing number of physicians in the US are serving as what in England would be called hospital consultants on full- or part-time salaries. Indeed if one includes industry, the Veterans Administration, the Armed Services, group practice clinics, and the various

Enjoy Your Environment

Dr. René Dubos of the Rockefeller Institute says you're not going to worry about the new poisons, and that you're too ignorant to know what to do even if you did decide to worry. This is how he sees it:

"Recent dramatic episodes such as those caused by air pollution in London, Donora and the Meuse Valley were special cases. Year after year, millions of New Yorkers drive out through the car exhaust of the Holland Tunnel into the garbage smells and industrial fumes of the New Jersey meadows; Los Angeles maintains its record growth despite its publicized smogs. The countries where synthetic chemicals are most widely used are currently the most prosperous and enjoy the longest life spans.

"The real dangers of environmental pollutants are their cumulative and delayed effects, that like those of ionizing radiations show up in the form of disease only years after initial exposure. The inhabitants of the industrial areas of Northern Europe become adjusted to soot, grit and smoky skies through exposure in their young age – but a large percentage of them suffer from chronic pulmonary diseases during the second half of life.

"Contemporary and disheartening ignorance of the delayed toxic effects of environmental pollutants is unlikely to be dispelled soon. It is easy to enact laws aimed at controlling the use of a few substances known to be toxic, but research facilities for long-range environmental investigations are scarce, young scientists are not encouraged to go into such studies, and there is little evidence that Congress, research foundations or medical schools are really concerned."

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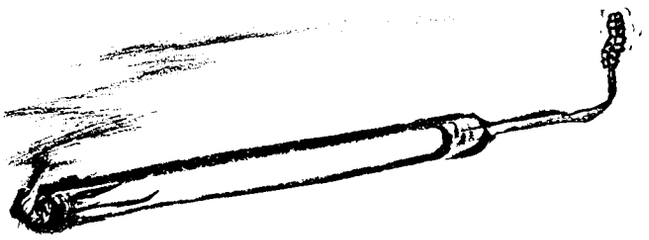
provisions for the medically indigent, very nearly a third of US professional medical work is already conducted on a salaried rather than the fee-for-service basis so sacred to the AMA. Perhaps even more important and more peculiarly American is the evolution of private office practice from the individual general practitioner to the group of qualified specialists. On the purely economic side there is an accompanying evolution of private and public insurance schemes – Blue Cross, Blue Shield, and the increasingly popular plans elaborated by private insurance companies for dealing with major medical costs or "catastrophes."

It is ironical that almost every step in this evolution has been vigorously opposed by the same forces that oppose the adoption of any over-all national medical plan. For as I have tried to show, it is the failure to establish a national plan that allows the evolution of these new forms to proceed.

There is still a lot of evolving to be done both along



paths already started as well as on some that are as yet scarcely descried. Premature emphasis on schemes for paying medical costs tends to obscure the question of what is being paid for and why it costs so much. Since good health is thought of as almost literally priceless, it is in any case embarrassing to ask about costs. When a surgeon may actually save a life by the timely removal of an appendix, it seems pretty small-minded to ask why he should charge 10 times as much as the internist who spends perhaps three times the effort trying to arrive at a difficult diagnosis. When specialist obstetricians working in marvelous hospitals do such a fine job, it seems at best impolite to ask how Holland manages to have a majority of its deliveries at home (most of them by midwives). Costs may be 20 times as much in the US, but it is hard to say that Americans are getting anything better for their money. Maternal mortality rates may be a tiny bit higher in Holland, but the US infant mortality rate is higher by a half.

Several years ago a comparative study showed that Swedish hospitals employ about two-thirds the number of people to take care of the same number of patients that American hospitals do. Admittedly, the study was relatively small scale and was published in a rather obscure way, but much the same point has been made over and over again by the easily available statistics on doctor-patient ratios in the two countries. The amazing thing is that so few people have ever tried to find out how the Swedes do it, and whether such facts have any bearing on hospital planning in this country.

At regular intervals since the last war the US has had a series of reports on medical care, its costs, and its needs. All of them include estimates of the need for various categories of personnel. In most cases these are simply extrapolations of existing trends. In no case have the authors seriously tried to find out how other countries manage to do such a good job at far less cost in terms of both money and personnel. In no case has the possibility of reducing US requirements for more surgeons by reducing the amount of unnecessary surgery even been suggested. Although many of these reports contain estimates of the probable need for what is known as ancillary or paramedical personnel, no serious attempt has ever been made to show how changes in the training and utilization of such personnel might be used to reduce requirements for the most expensive sort of professionals.

Public discussion of the medical care program has centered almost entirely on where the money is to come from and in what form it is to be paid. Think of the almost endless hours of discussions on such matters as fee-for-service versus salary, insurance plans which provide service (Blue Cross) versus those which provide cash payment, and last but not least whether old peoples' care should be paid for from general tax funds or by a special social security tax.

Occasionally, such discussions reach points which have some bearing on the cost and quality of medical care, as when it is pointed out that payment on an annual basis tends to increase service at the patient's option whereas fee-for-service tends to increase it at the physician's. For the most part, however, energy is burnt up in an endless defense of abstractions or irrelevancies. The current bickering over social security versus general tax funds as a source is only the most recent and perhaps the most absurd of these preoccupations.

One useful, though negative, result has been achieved by all this talk: by failing to adopt a national health plan of any sort, the US has at least preserved its freedom to experiment. There is no doubt that further experimentation is necessary before arrangements capable of providing a high level of care for all at a cost the country can afford are elaborated.

Some of the questions that should be looked into have already been mentioned – the fact that other countries achieve better results with fewer doctors, the encouragement the present American system gives to performance of unnecessary procedures at the physician's option, the wide variation in quality between the best and the poorest hospitals, the ridiculous disparity be-

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tween surgical and medical fees – a disparity which among other things encourages the ugly business of fee splitting and ghost surgery. These and other problems have been dealt with in more detail in accompanying articles. The only purpose of my remarks is to remind ourselves that the primary problem is not one of finding new means of paying for what American citizens are getting now. First, our policy-makers should be sure that when a means of payment is worked out, all Americans will be getting the best care possible, and at a cost which makes the most efficient use of all available resources. The country is not even close to either objective today.

Robert S. Morison

Summing Up: What Can We Do and What Lies Ahead

Health care, like education, should be available to everyone in the United States, and it can be. Whether looked at from the standpoint of the good life for the individual or the excellence of the society, its absence causes a large, measurable loss – one an affluent, civilized nation cannot, morally or economically, afford.

The cycle of poor health, low income, more poor health is not unbreakable. The use of hospitals, analyzed by income levels of the users as in the accompanying chart, shows that those who have substandard incomes need hospitalization oftener than do those with income in the upper brackets; and both groups in their final years are hospitalized with greatly increased frequency – the wealthier then overtake the poor.

The aged sick are penalized in many ways. Restrictive practices of prescription drug manufacturers bear on them harder than on others because their use of such drugs is much greater – and their incomes much less. Only 3.5 million of the 18 million Americans 65 and over have enough income to be liable to income tax. About one in four have little or no income beyond their social security payments; these average $77 a month. Few have appreciable savings – the liquid assets of one aged family in three total less than $100.

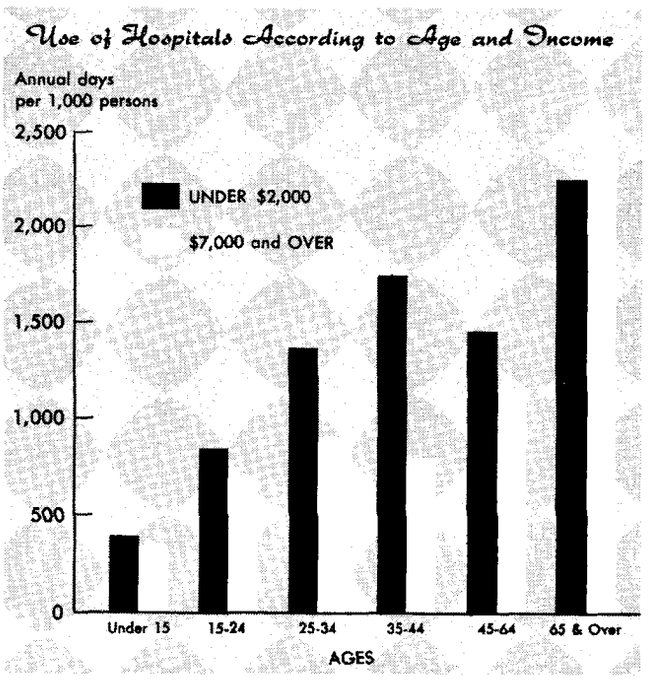
Furthermore, the 65-and-over group is growing fast: today, every tenth person is in it; by 1980 the total number will have grown from 18 to 24.5 million. One person in six in this group will be hospitalized within the next 12 months.

During the years of retirement, the average person can expect to have two or three, and the average couple five illnesses requiring hospitalization. Their average hospital costs will run around $35 a day; their average stays will be at least two weeks; their average medical bills for the year will probably exceed $900.

Yet of elderly patients discharged from hospitals, almost every other one (49 percent) have no hospitalization insurance. Fewer than one in three has enough of such insurance to cover as much as three-quarters of his bill. (Among citizens under 65, fewer than one in three are without hospitalization insurance, and 54 percent have enough to cover three-quarters of their bills.)

Very recently, insurance companies have begun offering new plans for the elderly, and in so doing have fully demonstrated the costs of insuring so high-risk a group. In its first 15 months of operation, the plan known as "Connecticut 65," a pooled-risk venture in which 32 health insurance companies participate, paid out over half a million dollars more than it collected.

The editors of *The New Republic* do not think that the financial prospects of the elderly are likely to change. In 1952, 9.5 million elderly persons were with-



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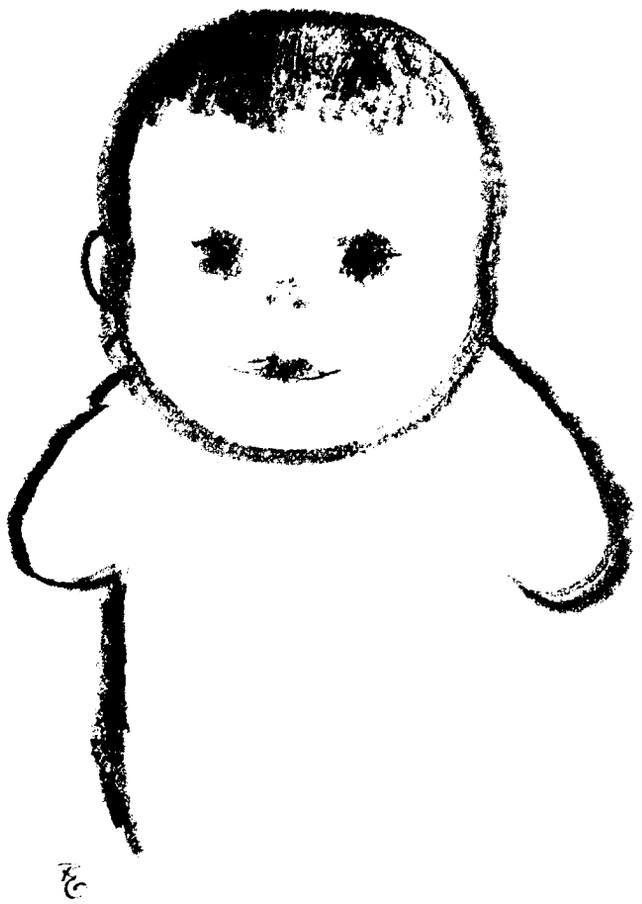
out any hospitalization insurance; 10 years later their number stood at 8 million. Passage of some kind of health care legislation along the lines of the program proposed by President Kennedy in 1963 for the aged is, therefore, a "must." The generation that is now elderly contributed in no small measure to the affluence of our present society; that society cannot be indifferent to the medical deprivation suffered by its aged.

By legislation, the country has already provided surveillance of what drugs may be marketed, with advantages instanced by this year's thalidomide scare.



By legislation, geographic availability of hospital care has been increasingly equalized as between rural and urban areas: of the 289,489 beds provided under the Hill-Burton Act since 1948, 91,171 were in areas of less than 10,000 population and another 94,522 in areas between 10,000 and 50,000.

In recommending "Medicare," we are mindful that it is a very limited measure – primarily concerned with sickness, not senility. Yet with lengthening life spans, brain damage due to arteriosclerosis and other circulatory difficulties is reducing more and more people to a vegetable existence that may go on for many years. In the absence of adequate nursing homes, many of these people are either uncared for or kept in institutions that are custodial warehouses for the forgotten. Public policy has largely ignored this side of elderly disease.

The dimensions of the senility problem approximate those of mental illness. Estimates of the unhospitalized senile place their number at around 700,000. About 9 out of 10 – 89 percent – of all patients admitted to mental hospitals for the first time when they are 65 and over are suffering from senile psychoses. About 91,000 of the 700,000 patients now in such hospitals are there for this reason. In proprietary nursing homes, 17 percent of all patients are senile. There is no recovery from senility.

Privately, doctors have for some time been discussing the morality of prolonging the life of the incurable and the senile. Does their Hippocratic oath to preserve life require them to continue the existence of someone with a catheter in the alimentary tract that introduces nourishment and a catheter in the urinary tract that removes waste? Families faced with the costs of such care as an alternative to education for their college age children are discussing such questions too.

The arguments against euthanasia are impressive; its acceptance would invite collusion between unscrupulous doctors and eager heirs and open the way to endless litigation. Who is to say when a disease is incurable? Who is to say that suicide is not a sin, or that killing, or even letting die, with intent, is not murder?

Yet must the individual concerned remain without choice? How many middle-aged Americans, reading of a sudden fatal heart attack, say, "Well, that's the way to go; I hope I can!" How many consult with their lawyers as to what kind of document, signed and sealed when there is no question of their competence, can simultaneously instruct and exonerate their physician, their family and their friends?

A few years ago Percy Bridgman, the Nobel prize winning physicist, contracted inoperable cancer. When the disease had progressed beyond the point of possible cure, he shot himself, leaving behind a note in which he observed that in a more humane society, this would not have been necessary.

Over the next decades, when the aged share with the very young the characteristic of being the fastest growing segment of the population, these matters are bound to be explored further. One interesting exchange took place in June, 1963, at the Atlantic City meeting of the AMA, when the Catholic Bishop the Rt. Rev. Fulton J. Sheen held a press conference where he said that if he were a hopeless cancer patient whose doctors were keeping him barely alive by a battery of tubes and devices, "I would ask them to take them out. I find no moral difficulty in this."

His statement was followed by one from Dr. Edward H. Rynearson of the Mayo Clinic, himself a Methodist,

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who declared: "It is wrong for doctors to see how long we can keep vegetables going. I want no part of it, for my family, myself, or my patients."

A parallel unresolved issue concerns development of inexpensive and reliable means of controlling births, morally acceptable to all religions. In the developing countries, annual increases in population wipe out the gains of modernized economies. India has an annual net increase equal to the entire population of Ceylon. In Latin America, the world's highest birth rates and rapidly falling death rates mean that however rapidly economies are "modernized," they seem never to be able to catch up with human needs. The fact that only 17 years from now US population, 179.3 million in 1960, is forecast to reach 245.8 million raises doubts that even this technically proficient economy, if its expansion does not exceed its current rate, will provide adequately for the next generation.

Here too medical and moral considerations converge. The Roman Catholic Church is not opposed to family planning; use of the rhythm method was approved long before the work of priests in remote regions of the developing areas reached its current proportions and so brought important segments of the church into direct contact with both the pressures of population on means of subsistence and the political alienation that comes with economic desperation. But the Catholic Church does not approve of various other methods of preventing conception, and because this is so, government action where Catholics have political importance is inhibited. In Puerto Rico, government and church after squaring off on this issue have come to an agreement; information on both rhythm and other methods will be made available through government clinics. In the US, the use of American foreign aid funds by recipient countries to further programs of population limitation is highly controversial.

Research on the medical side of this political-moral problem is requisite. The physiology of the rhythm method is too little understood to make it reliable in more than a given percentage of cases. Contraceptives in common use in Western countries, whether mechanical devices or pills, are far too expensive to be practical for use in the developing countries, even on the basis of government subsidy. The massive application of economic resources to this aspect of medical research is thus essential. Much has recently been said and written on the subject. The National Academy of Science's Committee on Science and Public Policy has just released a report on "The Growth of World Population." In January, 1963, the National Institutes of Health published an account of projects supported on its funds, "A Survey of Research on Reproduction related to Birth and Population Control." On August 15, Senator Joseph Clark of Pennsylvania introduced a resolution urging substantially increased birth control research in the NIH, with results made available to countries requesting assistance. His resolution calls for the establishment of a Presidential Commission on Population to consider the problem at home and abroad, particularly in its relation to economic and social progress. A position paper on this resolution is now in process of preparation in the Office of the Surgeon General.

The canvass of the difficult issues of life and death and economics provided in this supplement suggests three kinds of urgent agenda.

One concerns the institutions through which the quality of medical care received by the American people can be upgraded: more group practice; more regional arrangements to tie local doctors and hospitals into the developing know-how of the great research-and-teaching centers; more audits of performance.

A second concerns the devising and improvement of financial mechanisms, public and private, through which this care can be paid for, to make it available throughout the population.

A third is more subtle: it concerns the formation of policy, broadly acceptable across the country, in areas where agreement on forms of medical practice has yet to be reached.

The American people should get on with this job.

THE EDITORS

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The People's Flag is Colored Rose

by Malcolm Muggeridge

The fiftieth anniversary of the foundation of *The New Statesman* has been commemorated by, among other things, the publication of a history of the magazine by Edward Hyams. Let me say at once that my own personal involvement with *The New Statesman*, both as a contributor, and as a born Leftist, is far too intimate and deep-seated for me to be able to write objectively about Mr. Hyams' subject or his treatment of it. My father was one of the thousand or so original subscribers, and I vividly remember turning over the magazine's pages almost before I could read, certainly before I had the faintest idea of what they were about.

The New Statesman
by Edward Hyams
(St. Martin's; $7.50)

Thenceforth, there has never been a time when I have not read *The New Statesman* more or less regularly. At times, as I shall explain, I have disagreed with it more violently than with any publication, not excluding the *Osservatore Romano* and *The Chicago Tribune*. Even at such times, however, I have wanted to read it, if only to be enraged. It is also the case that Kingsley Martin, who edited *The New Statesman* with great journalistic brilliance for 30 years of its half century of existence, has been known to me, with varying degrees of intimacy, since 1930, when we were both writing editorials in *The Manchester Guardian* under C. P. Scott.

Our friendship, too, decidedly had its ups and downs; but we are both old now, and see one another fairly frequently. As it happens, I am driving over to see him this afternoon, in his house on top of the downs. We shall play a game of chess (which he is almost bound to win), and I shall tell him that I have been writing this piece about *The New Statesman*, and him, and Hyams' book, for the American magazine which is, I suppose, the nearest equivalent to the one into which he has sunk so much of his life, thought and effort.

As John Freeman (who succeeded Kingsley Martin as Editor of *The New Statesman*) points out in his Introduction to Hyams' book, the choice of someone suitable to handle such a theme was very difficult. If he had chosen one of the old faithfuls – say Richard Crossman, who would, of course, have done it gloriously – there were bound to be complications over the handling of this or that controversial episode. If, on the other hand, he chose a competent outsider, there would be the danger of producing just a public relations effort – competent, accurate, but totally off *The New Statesman's* wayward wavelength.

The choice of Hyams was really very astute. He is a talented writer and translater; a contributor to *The New Statesman*, for the most part on non-political themes; a scholarly, agreeable, suitably eccentric individual, who used at one time, as I recall, doggedly to plant vines among the hop-gardens of Kent, and make and bottle his own wine. Though, like the rest of us, I should assume that Hyams in his youth was pretty far to the Left, today he drolly combines an overwhelming admiration for Hippolyte Taine (and for most things French, including General de Gaulle) with whatever dregs of Marxism remain in his system. Essentially, he is a non-political animal.

The New Statesman is, of course, and has to be, an intensely political magazine. Thus Hyams' whimsical, or *non possumus*, attitude in this field produces sometimes rather curious effects; like an account of a Marseilles brothel by a novice at a nearby Convent of the Sacred Heart. He remarks, for instance, that any resemblance between stories of the atrocious behavior of the Soviet Government in Stalin's time as put about by hostile witnesses (I, incidentally, was one such), and the subsequent indictment of Stalinism by Khrushchev and others, is "purely coincidental." In the same sort of way one might observe that any resemblance between stories of Nazi atrocities as put about by Jewish exiles from the Third Reich, and what came out in testimony at the Nuremburg Trials, was purely coincidental.

In this sense, with all his amiability and literary skill, Hyams is poorly equipped to undertake a defense of *The New Statesman's* often equivocal attitudes toward the USSR, and international affairs generally, in the thirties. Indeed, as I remarked to Kingsley Martin, one might apply a famous remark of Oscar Wilde's and say that Hyams is defending him at the peril of his (Kingsley Martin's) life.

Hyams' *Apologia Pro Kingsley Suo* was taken apart pretty thoroughly by Conor Cruise O'Brien in *The New Statesman's* jubilee issue, in an article entitled "Chorus or Cassandra." Up to the early thirties, he concedes, Kingsley Martin manifested admirably the capacity, prevalent among Leftists generally, "to be surprised and angry when the man whom he expected to punch him on the nose, punched him on the nose."

So far so good. But then, O'Brien continues, Hyams goes off the rails when he contends that, by the middle-thirties, Kingsley Martin had thrown overboard his pacifism, and thenceforth provided his readers with a "hard" anti-appeasement policy. Not so, says O'Brien, and effectively, if not devastatingly, quotes chapter and verse to prove his point; for instance, successive pronouncements on the Czech crisis to the effect that (1) "We for our part, regarding war as the great-

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est of all catastrophes, and recalling the results of one war to prevent Germany from holding the hegemony of Europe, would applaud and support a decision on Neville Chamberlain's part to take Britain into isolation"; (2) "The question of frontier revision should at once be tackled"; and (3) "Nothing we or anyone else could do would save Czechoslovakia from destruction."

Nothing very "hard" about that, says O'Brien, and, of course, he's right. On the other hand, he overlooks the fact that he is confuting Hyams, not *The New Statesman* or Kingsley Martin, who never claimed to have a "hard" policy. In an article ("British Foreign Policy in the Thirties") in a subsequent issue, Kingsley Martin explained how, editing a Leftist weekly magazine in a time of great turbulence and change, a great variety of points of view inevitably found expression. It would be just as possible to demonstrate, by means of quotations, that *The New Statesman* was blood-thirstily bent on war-mongering as that it was supinely bent on appeasement.

The magazine, like any other Leftist publication, represented many, and sometimes conflicting, trends. It was anti-war and anti-fascist; it was against spending money on armaments and in favor of resisting aggression; it was for the Labour Party and often opposed to the Trades Union Council leadership. And so on. Out of all these contending impulses Kingsley Martin had somehow, week by week, in a dramatically shifting situation, to extricate a policy. As he put it: "We were not consistent, but outspoken." He, in my opinion rightly, attributes the success of *The New Statesman* in maintaining its influence and circulation through years (in which many other comparable journals foundered), to this outspokenness.

Kingsley Martin, in fact, as I have observed elsewhere, was during the years of his editorship our own fever and pain. Each week he was nailed to the cross on our behalf, given his drink of vinegar, and crucified, only to rise again for the next issue. He was a brilliantly successful editor precisely because he embodied in himself all the doubts and hesitations, the conflicting impulses and loyalties, often the sheer absurdity, of a Leftist position, and had no inhibitions in giving expression, vividly, skillfully, as he says outspokenly, to it. His "Critic's Diary," sustained with scarcely a gap throughout his editorship, was the personal expression of his confused state of mind, as the editorials were its public expression. As such, it is a kind of classic; a historical document from which posterity, if sufficiently interested, may deduce the whole character and anatomy of a 20th-Century Leftist.

I remember discussing him with Orwell, who held him in great disdain for many reasons; but particularly because Kingsley Martin had refused to publish the articles Orwell wrote about the Spanish Civil War, later embodied in his book *Homage to Catalonia*. Orwell was a very different sort of person. He was concerned about Truth as such, not with truth at the stone with a magazine to put to bed, and readers to interest and hold. As editor of *The New Statesman*, he could have been relied on to

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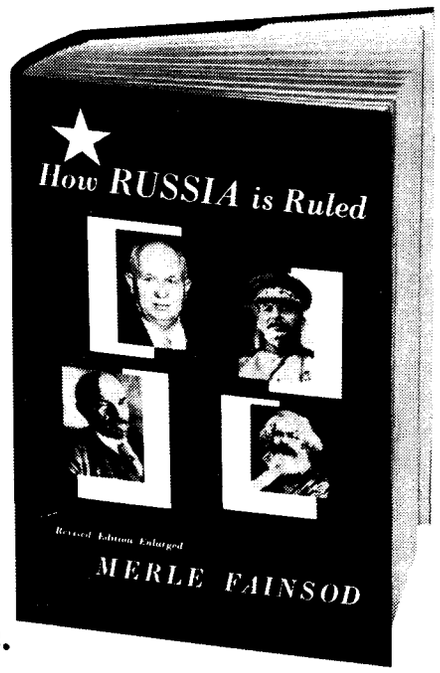
reduce its circulation and advertising revenue to negligible proportions in no time. Kingsley Martin's defense for refusing Orwell's articles was that, in the stage the Spanish Civil War was then at, "I should no more have thought of attacking the Negrin Government . . . than of finding excuses for Hitler when he was expected to invade England in 1940. You can't stab your friends in the back." In other words, as C. P. Scott wrote to me once in a note explaining why he had not used an editorial I had written, "there are occasions when truth should be economized in order not to make a hard task harder." Orwell was profligate with truth, and he loved making all tasks harder, especially his own.

My own chief contretemps with *The New Statesman* and Kingsley Martin arose over the attitude taken to the Soviet regime, especially to the monstrous cruelties which accompanied the collectivization of agriculture, which took place while I was a newspaper correspondent in Moscow, and the purges. There can be absolutely no question but that the magazine ignored, and sometimes assented to, Stalinist terrorism in the most barefaced and hypocritical manner. Here, too, however, it was only faithfully expressing the attitude of most of its readers. The flower of the English intelligentsia, led by the Webbs, Shaw, Laski, Cole, and, to a lesser degree, Wells, displayed an almost inconceivable credulity and callousness in accepting the pretentions of the Soviet regime and in overlooking its villainy. Why should lesser lights – schoolteachers, Quakers, art-and-crafters, free lovers, and so on – *New Statesman* readers to a man and woman – be expected to be more particular?

For years it used to give me apoplectic fits when I recalled those high-minded, and often well-heeled *New Statesman*-reading Intourists reverently surveying Stalin's stricken class-war battlefields, like vegetarians offering thanks in an abbatoir. Later, my furious indignation subsided, especially when Churchill, Roosevelt, Lord Beaverbrook, *The London Times*, crazed plutocrats like Joseph Davies, Cyrus Eaton, and other Establishmentarians, adopted a similar posture, if anything more sycophantic and absurd, without even the



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excuse, which the others had, of being misled by an original idealistic impulse. To mistake the Devil for the angel he once was is bad enough; but to fawn on him because he is strong, breathes sulphur, has rich gifts to bestow, and an inexhaustible blood-bank to draw on – that is truly contemptible.

So I fall back on the assumption that our sick civilization, as happens with sick individuals, is unconsciously seeking its own destruction and death. And in this quest, Leftist fantasies such as *The New Statesman* has purveyed, have their part to play. Our dreams, like Caliban's, are so delectable that when we wake we cry to sleep again – dreams in which affluence broadens down from installment purchase to installment purchase, and, dewy-eyed, we greet the nuclear dawn; and as each people rightly struggling to be free rightly attains its freedom, so do new prophets arise, Banda, Bella, Nkrumah, Kenyatta, beckoning us on to unimagined heights of peace, prosperity and happiness pursued. *La vie en rose;* the People's Flag is colored *rose.*

All this may seem a far cry from Hyams' estimable volume, which tells in a clear, pleasant manner how *The New Statesman* came to be started, and how it prospered and made an ever greater impact, not only politically, but also on its literary side, with distinguished literary editors like J. C. Squire, Desmond MacCarthy, V. S. Pritchett, and now Karl Miller. Clifford Sharp, its first editor, gave the magazine its original character; Kingsley Martin, his successor, as has been said, developed it to be the Left's burning and shining, if sometimes flickering light. His successor, John Freeman, the present editor, is a former politician, an accomplished television performer, and altogether a formidable mid-20th-Century figure of whom much more is likely to be heard. The Webbs founded *The New Statesman* to propagate their notions as to how society might be properly arranged; at a memorial service for them in Westminster Abbey, Lord Attlee, then Prime Minister in a Labour Government, remarked that everything they worked for had come to pass. In view of the then-state-of-the-world, in the immediate post-1939-45 war years, this might seem a somewhat dubious compliment. It was nonetheless deserved. Everything they worked for had come to pass, including *The New Statesman.*

FILMS

American, Past and Present

All The Way Home
(Paramount)
Mary, Mary
(Warner Bros.)
A New Kind of Love
(Paramount)

Admirers of James Agee's novel *A Death in the Family,* of whom I am not in the van, must have been to some degree disappointed in Tad Mosel's dramatization *All the Way Home.* Those who had relished the plummy, nostalgic texture of Agee's prose must have felt that they were getting skeleton for body. In at least one respect they will better enjoy the film of the play; for Richard Sylbert's *mise en scène* does a good deal to re-create the richness of Agee's remembered world of Knoxville, 1915, especially as aided by Boris Kaufman's camera.

But in other ways the film is a dilution of the play and thus a further dilution of the book. The gist of the play is that a generally loving couple stubbornly hold certain differing views and that, by his death, the husband wins the argument. The pregnant wife, out of love and loyalty, wants further to immortalize her dead husband by conveying his views to their son and their child-to-be. It is an idea of some poetic quality, but it is diminished in the film because the pair's original differences are softened, so the widow's change of mind at the end lacks the warm, welling effect it might have.

Robert Preston, the husband, hurts the picture because he is obviously too old for the part and because his snappy

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vigor sets Music Man limits to it. Jean Simmons, the wife, is, I believe, an underestimated actress; but her performance here is not quite focused, always just slightly blurry. It seems throughout as if she is just about to cut to the emotional core but she never really does. I would ascribe this flaw to the director, Alex Segal, who is adequate enough in camera management but, in acting, is content with broad, superficial strokes instead of fine, quick truth.

There is further questionable casting. John Callum, who plays the wife's brother, has unmistakable abilities but they do not include "sweet" parts; his description of the butterfly on the coffin is an embarrassment. Pat Hingle's name on a program is enough to tell us what we are going to get: another slice of folksy cornbread – not bad but no different from last time. Aline MacMahon, who is Aunt Hannah, always makes me visualize her listing in the Players Directory as: "Earth Mothers A Specialty." Her professional bosom-to-be-leaned-on bores me.

The film's greatest asset is the face of the child, Michael Kearney, who plays Rufus. He is well-enough handled – it would be loose to say that he acts. But it is his lively, homely face, as such, that generates whatever charm the picture has. The scene in which he visits his great-grandmother is irresistible as much for the apposition of his face and the antique woman's as for anything else.

Structurally the film sags. After the husband's death there is no dramatic growth or change until the very end, and that, as noted, is weak. The wife simply grieves in different ways, and the picture moves along on that keening keel. There is little in this script that is false or romanticized; yet the net result is only of reasonable facsimile. It proves again that in art it is not enough not to be dishonest.

Two comedies. Jean Kerr's play *Mary, Mary* exemplified that lady's way with wisecracks. It is not genuine wit, which, according to Fowler, must throw light; but she can generally find an amusing way to regard the commonplaces of urban and suburban life. As a playwright she has a mind made for Broadway – what one may call the one-set, small-cast mind that bespeaks a well-disciplined, almost schoolgirlish attention to the rules of success.

But, transposed to the screen, her play is hoist with its own ripostes. The one-set film – which, in effect, this is – is a challenge not to be met with wisecracks, particularly when a leading role is given to Debbie Reynolds. Miss Reynolds has shown ability in vernacular, wry drama, but she approaches each comic line like a member of a track team approaching a hurdle. If she does not actually trip and sprawl, we sigh with relief. Which is not the intended effect.

Barry Nelson, repeating his stage role, eventually gets a chance to warm up and, almost by sheer physical energy, flails a little vitality into his many scenes with Miss Reynolds. Michael Rennie looks too much like Edward Everett Horton to be taken seriously as the menace.

Mervyn LeRoy's direction and M. A. Merrick's recording are so poor that, among other faults, many of the lines simply cannot be understood. The clumsy editing by David Wages can be typified by a cut he makes from one shot of Miss Reynolds to another in mid-line: "This man writes like a sick (CUT) elf." Ina Claire herself could not triumph over that treatment.

One further point. Observant eyes can often note commercial plugs woven into films. For example, sometimes all the cars are provided by one large manufacturer: cheaper models for poorer families, middle-price models for middle incomes, and so on. This film tries another ploy. Mary, who lives in Philadelphia, is described as working for *The Ladies' Home Journal*. There are also mentions of *The Saturday Evening Post*, *McCall's*, and *The New York Journal-American*. Turnabout is presumably intended to earn fair play in those publications.

The mistakes of those whom one admires almost become one's own chagrin. I admire Paul Newman very much as a serious actor; his performances in *The Hustler*, *Cat on A Hot Tin Roof*, *Adventures of A Young Man*, and *Hud* are unexcelled in American films of recent years. But he is as unfitted for

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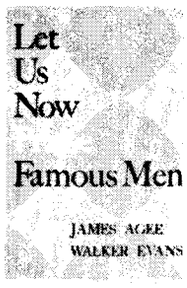

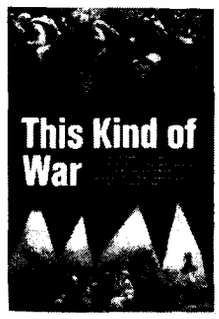

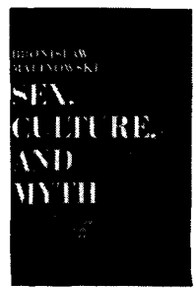

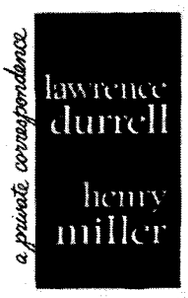

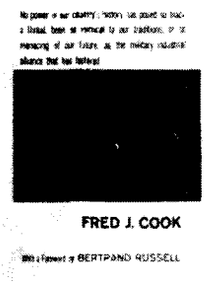

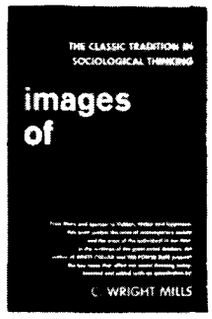

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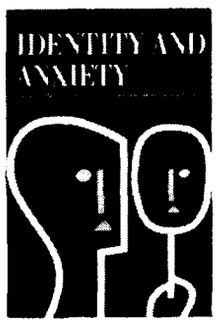

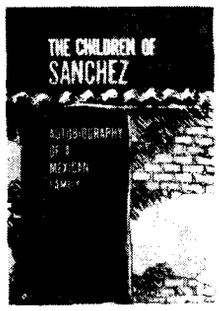

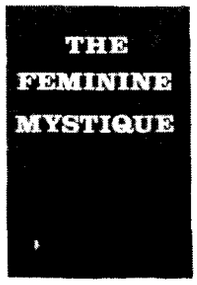

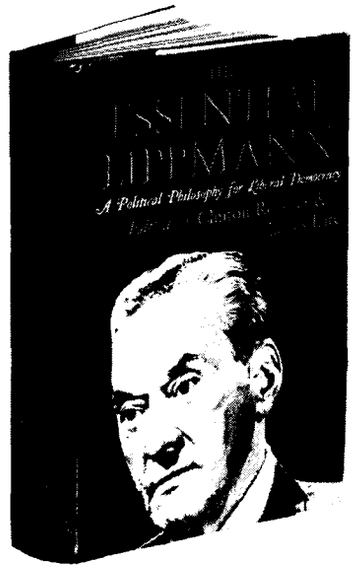

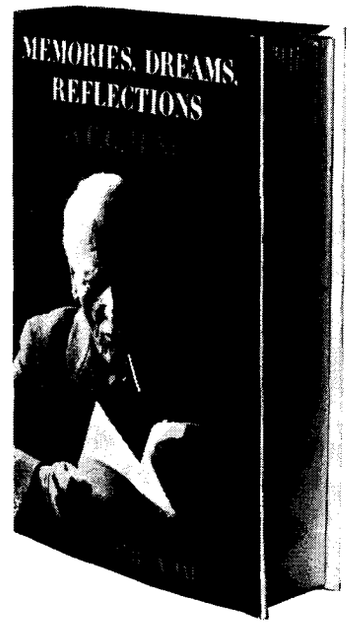

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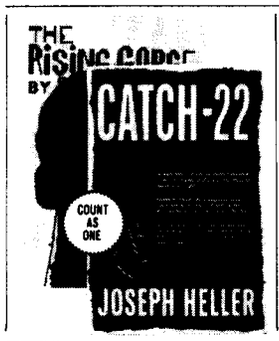

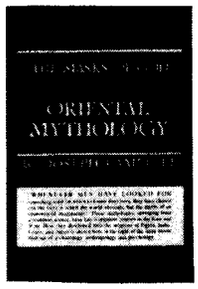

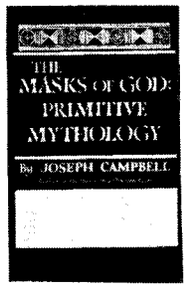

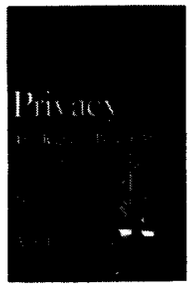

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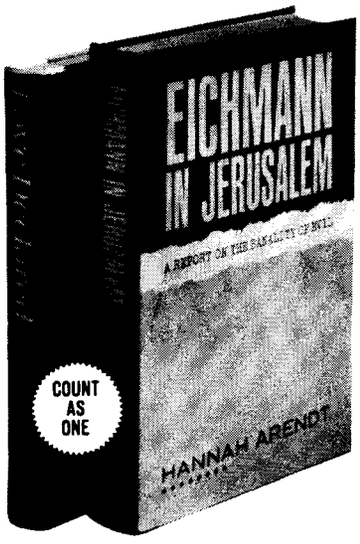

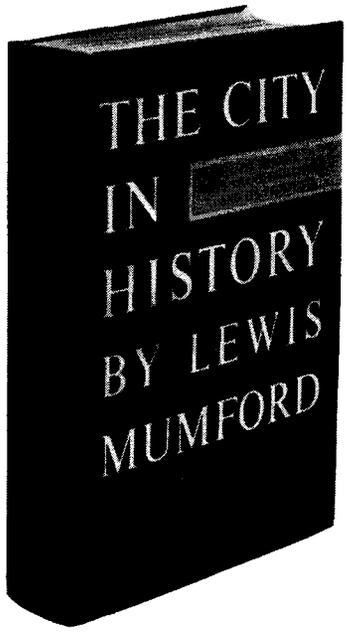

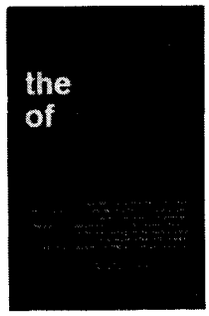

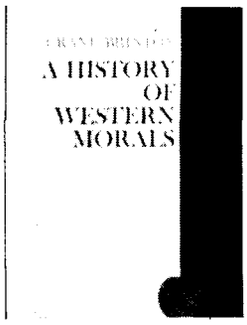

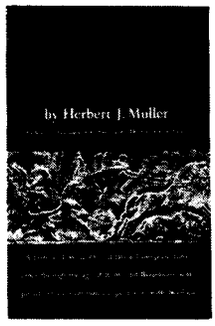

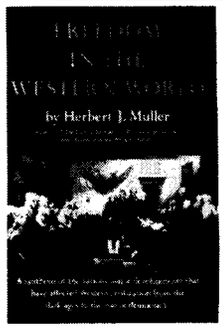

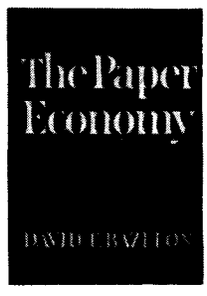

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comedy as he is for ballet, and he derogates himself by trying. In *A New Kind of Love* his co-star is his wife, Joanne Woodward, who too has some serious talent (although her voice is getting increasingly monotonous) but no *légèreté*. They are further encumbered by an offensively trite script about a free-wheeling reporter and a plain-Jane clothes designer who meet in Paris. She takes off her glasses, gets massaged and moded, and, by gad, she's beautiful.

Added to the lame imaginative devices that attempt to bolster the story is an extraneous vaudeville turn by Maurice Chevalier. The post-war return of Chevalier was a pleasantly sentimental occasion; it is now time to say, not *au revoir* but goodbye.

STANLEY KAUFFMANN

Correspondence

Policy & the Air Force Association

Sirs:

In his article of September 28 ("Air Force Rebellion"), Raymond D. Senter took a dim view of the Statement of Policy adopted by the Air Force Association at its recent Washington Convention. The statement opposed ratification of the nuclear test-ban treaty on the not-unreasonable grounds that the military and technological risks involved, in the Association's view, outweighed the political advantages which were being claimed by proponents of the treaty. Senter implied that the Association position was reached in a rubber-stamp fashion by a body of delegates made up of "retired Air Force personnel and aerospace industry contractors."

The position advocated in the annual Statement of Policy was arrived at independently and not without extended debate and discussion in both the Policy Committee and the Board of Directors before presentation to the convention. The statement reflects due consideration of the warnings contained in the report of the Senate Preparedness Subcommittee on the treaty and of the testimony of the Chairman of the Joint Chiefs of Staff that the Soviets can be expected to cheat.

Senter intimates that the statement was developed in cooperation with the uniformed Air Force. He offers no evidence, because there is none. He derides the constitutional provision of the Association which prevents active duty military personnel from voting on Association matters, participating in the formulation of Association policy, or holding any office in the Association. He says that this provision merely leaves the voting in the hands of "retired Air Force personnel and aerospace industry contractors."

It would have been an easy matter to have checked the membership of the Board of Directors of the Air Force Association and only a bit more difficult to have checked the roster of voting delegates. Of the 38 national officers and members of the Board, four would qualify for the first category, six for the second. It should also be pointed out that the company affiliation with AFA through our Industrial Associate program specifically prohibits industry participation in Association administration or policy formulation. These limitations on participation are scrupulously adhered to.

Senter appears to quarrel not only with the Association's position on the test-ban treaty, but even with its right to take such a position. In this he stands in sharp contrast to President Kennedy, who had encouraged free and open public debate on the issue.

In the October 5 issue Mr. Senter once more pursues his private devil, claiming to have uncovered an AFA plot to push American development of an orbital bomb. He cites an article in *The Atlantic Monthly* by Dr. Alton Frye, an article quoted with approval in *Air Force/Space Digest*, the Air Force Association magazine. In doing so, Senter managed (1) to miss completely the point of Dr. Frye's article, and (2) to omit the basic source for most of the public discussion of spaceborne weaponry.

Dr. Frye points out that the most telling argument in a meaningful US-USSR dialogue over banning weapons of mass destruction in orbit would be a known US capability to orbit such weapons and a simultaneous US capability to counteract such deployment by the Soviets. This is a long way from advoca-

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ting deployment of bombs in orbit by the United States.

Senter, while quoting the Defense Department's Dr. Fubini on the impracticality of bombardment from orbit, neglects to quote the authority with whom Dr. Fubini was wittingly, or perhaps unwittingly, taking issue. This authority is Dr. Donald J. Brennan, an eminent mathematician and president of the Hudson Institute. In the book *Outer Space, Prospects for Man and Society*, Dr. Brennan wrote:

> "Another possibility of a purely countervalue [counter-population-center] system that has been discussed, and which appears far more disturbing, would involve placing in orbit a limited number of devices of very large yield (a few hundred megatons or more) which could be detonated at orbital altitudes (say 150 miles) rather than be brought down to earth before detonation. The thermal effects from such a high-yield device could set fire to a large fraction of a continent, the extent of which would probably be limited only to that which could be 'seen' from the point at which the device was detonated, except that areas protected by cloud cover at the time of detonation probably would not be ignored."

Dr. Brennan obviously was raising a question, not advocating a course of action. Whether his calculations or those of Dr. Fubini are more correct is not the issue. The point is that the problem raised by the potential of orbital weapons is a serious one and cannot be dismissed lightly.

John F. Loosbrock, Editor
Air Force/Space Digest

In reply . . .

If top Air Force officers play no role in the formulation of AFA policy and editorial views, it is a stunning coincidence that AFA views have never deviated one iota on any issue from the publicly and privately expressed views of top USAF brass since the association was formed 15 years ago. When the Air Force asks for more B-52s or ICBMs, the AFA echoes this plea. When Air Force officers complain about cancellation of the Skybolt missile program or the nuclear-powered airplane, AFA's publication makes an anguished outcry. When civilian officials in the Pentagon reject Air Force requests for additional billions, they feel the editorial lash of Mr. Loosbrock and his associates. It is not surprising that AFA has long appeared to be the authoritative voice of the Air Force, which makes its frequent and harsh criticism of USAF's civilian superiors questionable if not improper.

The question of whether Dr. Brennan's much-quoted statement that an orbital weapon could set fire to a large fraction of a continent is closer to science fiction than to fact *is* indeed an issue, contrary to Mr. Loosbrock's opinion. If the Assistant Secretary of Defense for Research and Engineering, Mr. Fubini, is correct and Brennan is wrong, the value of the bombardment satellite as a possible terror weapon is completely shattered and with it the USAF's ambitions for a greatly expanded military space program.

Dr. Frye's contention that the US must develop orbital weapons to force the Soviets to agree to banning such weapons has been contradicted by the recent Soviet offer. Stories by Frye, Loosbrock (and others) leave readers with the implication that the US is not developing an anti-satellite defense to cope with the unlikely possibility of a Soviet nuclear weapon in orbit. The truth of the matter is that the Army, already responsible for anti-ICBM defense systems, has an anti-satellite system under development. If Mr. Loosbrock is not familiar with this, he should examine the testimony of Pentagon officials during the budget hearings earlier this year. Mr. Loosbrock might also re-read his own editorial of July 1958 in which he warned: "We cannot fall blindly in love with space for its own sake. For we have a few other matters to worry about as well." RAYMOND D. SENTER

Threat in South Africa

Sirs:

The fortnightly anti-apartheid newspaper, *Contact*, founded in 1958 by Patrick Duncan, is able to publish at the most two more issues before closing, if sufficient money is not quickly found to save it.

Apart from losing Patrick Duncan,

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who left the country in February this year; its editor, circulation manager and an editorial board member – Peter Hjul, H. S. Majija and Randolph Vigne – have all been banned by the Minister of Justice. Furthermore, a great deal of its financial support has been lost as more and more demands have been placed on sympathizers who have to find the money to support the families and pay for the defenses of the thousands before the courts on charges under the Sabotage Act or held under the misnamed 90-day clause of the No Trial Act. Two major actions against *Contact*, both for publishing news forbidden by the various "emergency regulations" have also depleted our funds and our situation is now desperate.

Once an unofficial organ of the Liberal Party of South Africa, *Contact* has broadened its interests and today campaigns for "united non-racial action" for freedom in South Africa.

We believe that the voice of freedom must continue to be heard in South Africa and that constructive ideas and news that the daily press is often not prepared to print must continue to find an outlet if democrats are to have any chance of minimizing the violent clash for which the government seems to be preparing itself. Extreme financial difficulties brought about by the present situation in South Africa therefore forces us to appeal to those of your readers who support our cause to kindly send donations to: *Contact*, P.O. Box 1879, Cape Town.

Harold Head, Editor

"PROBABLY NO AMERICAN *can understand the Asiatic concept of 'face.' This is perhaps fortunate. In view of how much 'face' the U.S. has lost in the Orient, we would have to burn Washington to recover it.*" Clare Boothe Luce, writing in the current issue of National Review.

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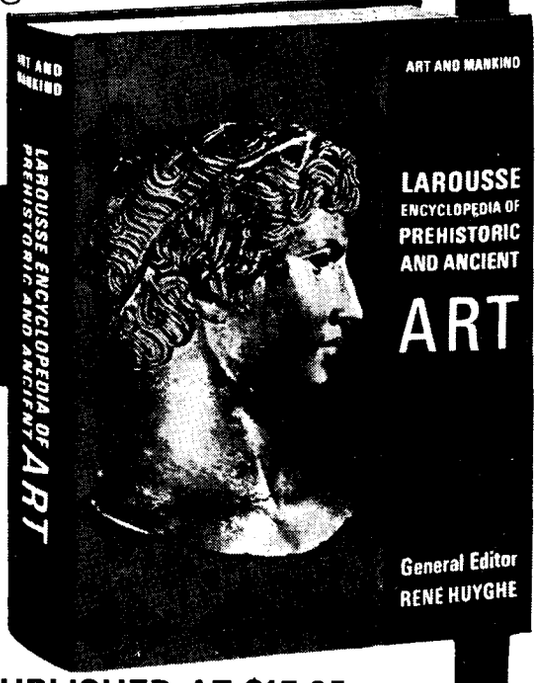

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